HOW THE NEW LABOUR GOVERNMENT THIRD WAY POLICIES (1998-2010) AND THE DELIVERY OF THE NEW DEAL FOR COMMUNITIES (NDC) REGENERATION PROGRAMME IMPACTED ON PARTICIPATION IN HEALTH CARE IN AN AREA-BASED INITIATIVE

F. J. GREENHAM

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A longitudinal study using action-learning research methodology in a New Deal for Communities Area Based Initiative

Felicity Jane GREENHAM

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Department of Peace Studies and International Development

University of Bradford

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Abstract

Candidate: Felicity J. Greenham

Thesis Title: **How the New Labour Government Third Way policies (1998-2010) and the delivery of the New Deal for Communities (NDC) regeneration programme impacted on participation in health care in an area-based initiative.**

Key Words: Community Governance, Social Capacity, Public Health, New Deal for Communities, Participation, Health Inequalities

The research examines New Labour's Third Way policies and the impact New Deal for Communities (NDC) regeneration programme had on participation in health care. This longitudinal study (1998-2007) explores participatory joint working, welfare state, social capacity, health inequalities, citizen involvement and community capacity. It captures the experiences of local community and front-line workers whilst delivering the Health Focus Group (HFG) in the NDC programme. Using action learning reflection techniques, the study analyses a purposeful sample of 15 from the local community, front-line workers, and strategic respondents involved in the NDC health programme.

The research demonstrated the NDC did increase participation, joint working and involvement of local actors 1998–2003. The importance of communication, leadership and relationships was recognised as an important catalyst for developing community governance models. The new action learning spaces initiated, designed and delivered 19 new models of joint local clinical, community and complementary health and well-being projects.

In 2001, New Labour introduced public private finance initiatives with the Primary Care Trust (PCT) which conflicted with the local actors' involvement in the participatory joint decision-making. The reconfiguration of health and social care services and the new public health models introduced complex governance and monitoring models, further distancing the local actors from the process. Strategic staff changes in key governance positions also adversely affected the communication and trust established with local actors.

The research concluded operational, tactical, and strategic alignment is necessary to maximise joint participation in decision-making.

Acknowledgement

This piece of research has been an important part of my life for a very long time. The twists and turns that it has taken have been many and the hills that I have had to climb to reach this point have been substantial. I am grateful to and wish to first especially thank two people who walked besides me and stayed with me throughout the long journey, my wife Gayle and my supervisor Graeme Chesters. This thesis exists because of your consistent understanding and encouragement. Thank you.

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Thank you all.

Dedication

This thesis is dedicated to the amazing people in the NDC who allowed me to be part of their lives and without whom this research would never have happened. I was challenged to look further at the lessons of that time and I have a huge debt of gratitude towards all those remarkable people. Thank you for the everyday lessons, the acceptance, and trust and for letting me into the spaces, and your lives. I was privileged to work with and for you; especially the wonderful group of local residents who were prepared to spend time and energy challenging me alongside developing their own health and well-being services.
This research was essentially about rebalancing the local actor's inequality of opportunity, to have voice and participate in the collective spaces that shape our own local services.

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ABIs	Area Based Initiatives
AHR	Annual Health Report
ALR	Action Learning Research
ALS	Action Learning Set
BLC	Big Life Company
CAG	Clinical Advisory Group
CEO	Chief Executive Officer
CESR	Centre for Economic and Social Research
CFPS	Central Fraud and Probity Services
CHAP	Community Health Action Partnership
CHD	Coronary Heart Disease
CHC	Community Health Council
CLG	Communities and Local Government
CBPR	Community-based Participatory Research
DC	District of Columbia
DETR	Department of the Environment Transport and the Regions
DHSS	Department of Health and Social Security
DoH	Department of Health
DP	Delivery Plan
EPP	Expert Patient Programme
GP	General Practitioner
HAP	Health Action Project
HAZ	Health Action Zone
HFG	Health Focus Group
HImP	Health Improvement Program
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
HM	Her Majesty's
IPPR	Institute for Public Policy Research
JIP	Joint Improvement Plan
JRT	Joseph Rowntree Trust
LA	Local Authority
LDP	Local Delivery Plan
LHA	Liverpool Health Authority
LIFT	Local Implementation Finance Trust
LMCA	Long-term Medical Conditions Alliance
LPS	Local Pharmacy Service
LSP	Local Strategic Partnerships
MASTHAZ	Manchester, Salford and Trafford Health Action Zone
MP	Member of Parliament
MSTHS	Manchester Salford and Trafford Health Services
NDC	New Deal for Communities
NDC DP	New Deal for Communities Development Plan
NHS	National Health Service
NHSE	National Health Service England

NICE	National Institute for Health and Clinical Excellence
NR	Neighbourhood Renewal
NRF	Neighbourhood Renewal Fund
NRS	Neighbourhood Renewal Strategies
NRU	Neighbourhood Renewal Unit
NSF	National Service Frameworks
OECD	Organisation for Economic Cooperation and Development
ODPM	Office of the Deputy Prime Minister
OHE	Office of Health Economics
PCT	Primary Care Trust
PDG	Project Development Group
PFI	Private Finance Initiative
PMS	Personalised Medical Services
PPFI	Public Private Finance Initiatives
RISU	Revans Institute Salford University
RTCC	Real-Time Community Change
SEU	Social Exclusion Unit
SRB	Single Regeneration Budget
START	Salford Training and Arts
TLC–PPI	The Leadership Council – Progressive Policy Institute
WHO	World Health Organisation

1: How the New Labour Government Third Way policies (1998-2010) and the delivery of the New Deal for Communities (NDC) regeneration programme impacted on community participation in health care in an area-based initiative.

1.1: Introduction: A personal perspective: how my previous work influenced the focus for this research

The chosen research and the method of enquiry are rooted in my experience of working in health programmes in deprived areas. Before this unique research opportunity, I had been involved for three decades in a variety of different roles that experientially allowed me to acquire insight into participatory ways of involving people whilst also developing my clinical, interpersonal and collective group relationship skills. I believe that reflection and action, as part of a process of people making decisions for themselves, is critical for people to take greater control. As a public health clinician in the mid-1970s, I learnt that community work and working directly with people was central to supporting transformative change. I experienced community as a space for critical pedagogy and as an environment to be understood to help nurture the dynamics of participatory democracy. I also valued the importance of working with citizens directly to develop their own solutions to the problems that affected their lives. I had many opportunities to work directly with a range of voluntary and statutory actors inside geographical areas which had high levels of poverty and poor health. In the mid-1970s, I experienced the impact of social deprivation and poverty on individuals, families and communities, an impact that was not acknowledged politically until a decade later (Townsend & Davidson, 1982). Social policy discourse started to link the welfare state, education and the environment to the economic costs related to disease in the eighties (Fraser, 1984). Prior to 1997, the correlation between health inequalities, life expectancy and health and welfare services were not widely discussed in the public domain. Conventional analysis of the politics of poverty and a failure to acknowledge its key interrelated elements had helped separate politicians from citizens with first-hand experience of poverty and the ability to help shape solutions (Beresford et al., 1999). The Conservative government had commissioned the Black Report (1980) but their findings were not published as public policy until a decade and a half later. A shift in public policy occurred when the Acheson Review, an investigation into the findings of the Black Report on health inequalities was published in 1998 and those results were widely distributed by the New Labour

government. In 1997 the New Deal for Communities policy introduced participatory working, the subject of this thesis.

1.1.1: My insider position in a Health Action Zone (HAZ) as New Labour came into government

My previous work experiences in community nursing and working with people living with the Human Immune Virus developed and enriched my understanding around the dynamics of self-management, participatory engagement, local democracy and communities (WHO, 1992). In 1998, I was energised and excited to find myself working in one of the first waves of the new government's policy zones. These flagship structures were seven-year-funded, multi-agency partnerships aimed at reducing health inequalities. I was based in the Manchester, Salford and Trafford Health Action Zone (MASTHAZ) and thus able to contribute directly towards the implementation of the New Deal for Communities (NDC) regeneration process. With the election of a new government, I believed we had the opportunity to begin to address inequalities through collectively working together, within neighbourhoods, by listening to communities and using participatory empowerment processes. I was optimistic that we would be able to work in a different way to support community reciprocity, enhance capacity and help to build strong communities.

The Manchester, Salford and Trafford Health Action Zone (MASTHAZ) chose four sites with populations of approximately 10,000 to work within, to develop an integrated and joined-up approach that involved the local citizens. I was given a key role as a Health Development Manager to concentrate on one of those sites in a northern, area-based initiative, which, for the purposes of anonymity and confidentiality, I call Wassail and Boothtown throughout the thesis. This health action site was chosen by the local authority partners to be submitted for Pathfinder status (ODPM, 2001) and which subsequently received NDC funding. The area-based initiative targeted substantial parts of two wards ranked as the 201st and 1,542nd most deprived wards in the DETR's index of multiple deprivation (2000). The community was defined by natural boundaries which included a major road to the south and north, the river to the east and the Manchester – Bolton railway line in the west. It contained 3,432 households and 9,750 people. The predominant population was white with only 1.8% of ethnic minority origin. The area had a mixed tenure, split between council owned (49.3%),

privately owned (38.1%), privately rented (7%) and rented from housing associations (7%). (NDC Delivery Plan, 2001: 4).

As a practitioner researcher working inside this Health Action Zone in 1999, I used my prior experiences and skills to connect actors and support an environment that helped enhance communication, facilitate participatory action and involve local citizens (Beresford & Croft, 1993). This often involved communicating and interconnecting what was happening at the operational, front-line, community levels with the tactical and senior management strategic levels. Right from the start of my involvement on behalf of the Health Action Zone (HAZ) organisation, as a Health Development Manager, I was working along both the vertical and horizontal axes, introducing and facilitating partnerships, engaging local people and communities and using participatory processes to help facilitate and plan the NDC health programme. In 2000 I introduced action learning research sets (Revans Institute, 2002) into the NDC work and the data emerged as we began a process of discovering what people wanted from their health services. The lessons learnt from this longitudinal, ten-year study reflect and follow the twists and changes of central control and Treasury policy decisions, such as the implementation of the Public Private Finance Initiatives (PPFI) in 2002/3 and Local Improvement Finance Trusts (LIFT) in 2001. This research documented the respondent's experience of community governance and citizen involvement in local decision-making. The research data identifies and captures the tensions between the competing demands on the New Deal for Communities (ODPM, 2001) to meet the regeneration policy targets and to deliver changes in the physical environment, and in the health and social infrastructure.

1.2: The complex political and social policy framework

New Labour came into power and introduced its Third Way ideology, heralded by Giddens (1998) as a rational response to a new political, social and economic environment with, at its heart, a belief in the value of community and a commitment to equality of opportunity. The thesis explores the introduction of New Labour's political and social policy framework and researches how these new participatory processes, specifically within the NDC regeneration programme, are experienced by the local people and the front-line workers. A key goal of the NDC policy was to encourage the active involvement of local community members as partners in the decision-making

processes, together with the other statutory, voluntary and private partners operating in the area. The NDC was to establish six new focus group forums, whose membership comprised all these partners and included local community representation. The focus group forums would then agree on the main issues, define solutions and prioritise how the new funding of £53 million awarded by the NDC, and distributed over a 10-year period, would be spent. These decisions were to be ratified locally by a newly established NDC Partnership Board in each of the area-based initiatives (NDCDP, 2001). The original 39 NDC partnerships had to create their own individual governance arrangements, ratify their operating procedures and make decisions related to the composition of their boards, focus groups and staff teams. Additionally, they had to establish systems for monitoring and financial management whilst establishing NDC partnership board autonomy and an arm's length management structure separate from the local authority (Fordham, 2010).

New Labour suggested that the introduction of the NDC policy would help identify the main issues and solutions and support greater involvement of the community in both rebuilding their own community structures, and reducing the inequalities gap. The thesis examines whether the introduction of New Labour's Third Way political discourse did increase local citizen governance by harnessing social capital. The NDC programme envisaged local people as key architects, involved in the design of their own health services ostensibly to reduce health inequalities and close the health gap (Acheson et al., 1995). The thesis explores the impact, as experienced by the local respondents along the longitudinal 10-year time framework, of the introduction by central government of these new regeneration policies. It also documents within the same time framework the policies introduced simultaneously by the Treasury Department alongside the Office of the Deputy Prime Minister Department of Communities' implementation of the NDC regeneration programme. The thesis questions, conversely, if New Labour's policies were a continuation of a neo-liberal market response to harness social capital to facilitate capacity, policies driven by the central government's reduced financial allocation for health and social care services.

1.3: Structure of the thesis

Chapters 2, 3 and 4 of the thesis explore social policy and the political and economic framework by examining the newly emerging spaces for partnership inside of the

restructured health and social care delivery system as New Labour came into power (Leat et al., 1999; Newman, 2005; Pratchett, 1999). Recognising the interrelated themes of citizen participation and community engagement, the wider determinants of health and the influences of central government policies, within these introductory chapters my thesis documents the complex political and social policy context. It also acknowledges the policy context and wider environment that the NDC programme was introduced into.

Chapter 2 documents how, during the 1990s, the concept of '*community governance'* and Social Capital theory emerged at a strategic level as a process for policymakers, which necessitated the development and operationalization of a multiplicity of forms of community level control (Leat et al., 1999). Chapter 3 adds an understanding of the structural policy, conceptual and organizational frameworks that the NDC programmes operated in as they targeted geographical areas of acknowledged multiple deprivation and socio-economic inequalities (Dahlgren & Whitehead, 1991). Chapter 4 explores the delivery of the NDC programme amidst the conflict and challenges arising from the reconfigured finances of the health sector.

Chapter 2 focuses on the development of citizen participation and community governance, relating it to the dynamic environment changes after 1998 when New Labour introduced its health and social care policy frameworks. The political imperative for greater public participation has been around for a long time and the idea of extending and strengthening participation in health care was not uniquely a New Labour concept. There are numerous examples of previous attempts to strengthen the public's voice and involvement in health service provision. Examples introduced by the preceding Conservative government (1979–1997), such as the introduction of Community Health Councils (1992–2003) the Patient's Charter (1991) and the Regional Health Information Service for Patients (Webster, 1998), demonstrated a few of the variety of targeted approaches which had been introduced prior to New Labour (Jordan, 2010). A range of welfare service user movements emerged between 1960 – 1990, including collectives of disabled people, mental health service users, people with learning disabilities and people living with HIV/AIDS, due to a dissatisfaction with the service they were receiving (Beresford, 2016). Chapter 2 also discusses the importance of social policy theory, and explores the well-being and self-management

agendas, reciprocity, social cohesion and outcomes for individuals and collectives within participatory engagement (Beresford & Croft, 1993; Coleman, 1988; Pickin et al., 2002; Kickbusch, 1981; Hunter, 2015; Popay & Williams, 1998a). The NDC (ODPM, 2001) targeted the social capacity of communities by introducing an area-based policy which explicitly encouraged local democratic participation of the diverse actors in the decision-making process). The national strategic action plan based its vision on the objective that '*within 10 to 20 years, no one should be seriously disadvantaged by where they live*' (SEU, 2001).

Chapter 3 observes the historical trajectory of the NHS, the welfare state and health inequalities within deprived communities in the preceding decades, (Seedhouse, 1986; Acheson, 1998; Black et al., 1980). It examines the health policy framework pre and post 1997, the complex dynamics with the key actors and the structural reorganisation into local neighbourhoods that New Labour inherited. The chapter surveys the literature related to health inequalities and deprivation which had previously been interpreted through the prism of the NHS (Townsend, 1987; Wilkinson, 1996). The research recognises that in order to tackle the widening health gap (WHO, 2008) the NHS, National Service Frameworks and regeneration policies which had previously worked in isolation from local communities needed rebalancing between state intervention on one hand and a person's right to choose on the other (Crowley & Hunter, 2005; Beresford et al., 1999). The research environment included the wider components contributing to ill health as well as the impacts of implementing the NDC policy on the newly emerging, complex partnerships and joint, performance-management systems (Wanless, 2002; Diamond & Liddle, 2005). The New Labour NDC programme, announced in 1998 as part of the government's National Strategy for Neighbourhood Renewal, was one of the most important, well-resourced, area-based initiatives ever launched in England (SEU, 1998). This model was introduced ostensibly to specifically target disadvantaged communities, using a participatory '*joined-up*' approach which would stimulate citizens towards sharing joint decision-making. Each NDC forum received £50 million over a 10-year period to develop local improvements addressing poverty, unemployment, and poor education, and to address health inequalities (Acheson, 1998)

Chapter 4 explores the introduction of the New Labour strategic policies and reviews the impact on the emerging operational health and social care systems as these health policies were introduced and embedded. The Third Way was introduced as a paradigm shift with New Labour focusing on the welfare state and levelling up the inequality gap (Boyle, 2002), to encourage social inclusion and provide equality of opportunity. Chapter 4 acknowledges that health policies do not exist within an ideological vacuum and a shift from the unequal provision of health services characterised by the delivery of systematically poor provision to certain locations and segments of society to a more equitable shared health care system would be influenced by financial policy, competitive markets and globalisation (Stafford et al., 2008; Greener, 2006).

New Labour introduced a range of new health partnership frameworks to preside over regional and sub-local institutions and designed to impact on the collective life of democratic society (Bauld, et al., 2005; Jordan, 2010). These frameworks are critically explored in Chapter 4. A key theme of the thesis is how the emerging, new, health partnerships within the NDC health focus group were experienced by local actors and whether these new spaces supported the developing debate about a more democratic participatory health system (Gaventa, 2004; Cornwall et al., 2004; Putnam, 2000).

NDC Pathfinder status was awarded to post-industrial urban settings where a population of at least 10,000 people was experiencing economic, social and physical infrastructure decline. Chapter 4 discusses the active citizen agenda strategies that the NDC introduced with the new, participatory, community - involvement strategies, whether the emerging models allows citizens to become actively involved in implementing the governance and decision-making NDC health programme processes, and whether they feel supported.

Chapter 5 introduces the research journey and the methods I used to collect the data. The thesis studies the 10-year implementation of a regeneration policy introduced in 1998 and the research has a 20 year gestation. The stages I explore to develop the contours of the final research strategy are examined here and I explain why I chose an action-learning research methodology. The chapter records the processes that the research used as it observes and documents the respondents' lived experiences (Becker, 1998). I collected data from 15 respondents, a small purposeful sample of local community members, operational front-line workers and statutory sector tactical

and strategic managers. I acknowledge that the purposeful sample is limited and am cautious around the generalisability or transferability of the findings. The central context of the research is to document the inside voice of the citizens, to describe the emergence of new participatory spaces and capture the citizens views on participatory involvement and governance. The research focuses on the perception of the actors within an operational, tactical and strategic field and how they experience the impact of the introduction and changes throughout the delivery of the NDC programme.

The research analyses their thoughts on their perceived levels of involvement and the extent they feel integrated as local people and front-line workers into delivery of the NDC programme, as the regeneration and welfare policies were implemented. This method of data collection captures the insider voice of respondents who lived and worked in the NDC area during the programme.

As an insider researcher, I began data collection while I was employed as a Health Development Manager in the MASTHAZ and continue whilst working directly for the Primary Care Trust and Local Authority delivering the NDC regeneration programme. I specifically focused on data collection from the respondents involved in the health focus group forum and from the community health action partnership.

One of the conditions of implementing the NDC policy necessitated demonstrating partnership working with local people. The methodology chapter analyses whether implementing the NDC health focus group programme did enrich, stimulate and increase participatory democratic discourse and develop community governance models throughout the 1999-2010 ten-year timeline. My data collection and analysis involved questionnaires and interviews with the respondents, NDC and health focus group minutes and documents, contemporaneous notes of mine and the respondents' action-learning, reflective journals, plus published NDC reports and other relevant documents.

As the joint LA/PCT Health Development Manager, I was seconded from the HAZ into the NDC in 2001, and until 2004 I collected data inside the area-based initiative. This involved capturing, on multiple levels, the particular synergistic actions that were mutually reinforced by front-line workers and local people inside the geographical regeneration area. This effectively became the vertical axis for the study and the

horizontal axis was the point at which the tactical and strategic, statutory and political actors intersected. Within an increasingly complex policy environment, the research was mapped across these vertical and horizontal axes. Between 1999-2004 timeline, the first data was collected from the respondents. (This included journals, minutes, published papers and contemporaneous notes.) This data was then analysed against a timeline of the central government's activities. In 2007 I completed a semi-structured questionnaire with the purposeful sample of 15 respondent (Appendix 2).

Chapters 6, 7 and 8 describe and analyse the democratic participatory spaces that the NDC programme opened up from the perspective of 1) local community members, 2) front-line workers and 3) strategic managers, respectively. As a social scientist inside the NDC initiative I used data that I collected by the participatory, action-research learning and reflective practice to progressively analysis, interpret and refocus the development of the NDC health focus group programme. This reiterative process allowed me to elicit meaning, helped sustain knowledge generation and enabled me to develop a framework for interpretation, reinterpretation and analysis of the emerging themes. The insights gained from this integrative process are used in the analysis chapters 6, 7 and 8 (Millar & Crabtree, 1999).

The three data analysis chapters examine, through a multidisciplinary lens and across a longitudinal timeline, the 15 individual respondents' experiences of the new area-based, participatory spaces that the New Labour localism agenda and NDC policies introduced. The data analysis identified and clarified the emergent themes, and documents the conclusions and emergent learning. The action learning process enabled me to understand the ways in which respondents experienced the issues as they emerged. To refine and understand and distil the data further, categorising, coding, reviewing, identifying themes and organising the key categories are used as a framework for further interpretation (Stringer, 2007: 104-112). Chapters 6, 7 and 8 analyse the data relating to the new democratic spaces and experiences, question whether the NDC programme offered greater involvement for respondents, and explore the extent which the respondents determined their own local health care priorities.

Chapter 6 compares the data collection from the local community respondents against the context of the emerging ideology and strategy of central government (Giddens,

1998), and the extent to which the new, evolving, social-capacity-theory debate located civic engagement as a solution to addressing economic decline (Colman, 1988; Putnam, 2000; Ferragina & Arrigoni, 2016). It analyses why respondents initially became involved in implementing the NDC health programme and how this participation was experienced over the first four years of the programme's implementation.

In Chapters 6 and 7, the analysis reflects on how the local respondents and front-line workers involved in the NDC contribute to greater community participation both in the NDC health focus group and in the reconfiguring of health and social care services within the area-based initiative. Chapter 8 compares the strategic respondents' involvement in the NDC programmes and their experiences and views. These three analysis chapters document the impact of opening participation to the local actors, describes the opportunities that emerge in the new spaces, and documents the respondents' opinions of what the NDC programme offered.

Chapter 9 expands on the previous discussion and summarises the key findings relation to the introduction of centralist New Labour Third Way policies and the emergent public spaces which aimed to harness the social capacity of front-line workers and local people, join up health and social care services and increase control in local decision-making.

My research suggests that the introduction of New Labour's regeneration policies was a continuation of the previous government's neo-liberal ideology to harness community capacity. Whilst a key theme shows that the introduction of the NDC regeneration policy did increase participation of local actors and joint working from 1998 to 2003 in the ABI, it also concludes that all the respondents' data documents that the levels of participatory working involving the LA-PCT changed in 2003/4. This is explored further in Chapter 9.

1.4: Context for the research setting and the theoretical framework

The research was set within a ten-year timeline as the New Labour government introduced its Third Way and NDC policies and explores the wider context and the dilemmas that arose with implementing a complex, social-change agenda. The research notes that one part of government was trying to open up unpredictable,

participatory, deliberative democracy processes under the NDC (Cornwall et al., 2007). The research also documented that, whilst the NDC policies were encouraging neighbourhood regeneration and community engagement in health service decisions, the Treasury Department policies initiated an increased focus on public / private partnerships (Greener, 2006; Hellowell, 2012; HM Treasury, 2012) as a means of increasing capital financing and improving the quality of health service provision. The introduction of centre-driven, public / private partnerships (Terry, 1996; Hellowell, 2012) and funding arrangements that are determined by the Treasury is explored in the research as it impacted on the introduction of community engagement policies (Ledwith & Springett, 2010; Leat et al., 1999). The potential conflicts between central and community goals are further explored in the body of the thesis. The research also explores the themes that emerged from the analysis and the impact on public spaces, public health improvement and community governance models that the NDC regeneration policies (ODPM, 2001) stimulated.

1.5: Impact of the research

This research documents the impact of the implementation of the NDC national policy in the lives of 15 respondents, recording how these community and front-line workers engaged with, and experienced, the new participatory spaces. The new participatory processes and spaces offer an opportunity to observe the emerging narratives of the community and the policy actors. Within this new culture, the research captures the respondents' actual experiences of increased community capacity, involvement, personal resilience and the transferable learning available to support today's localism and neighbourhood agenda (Figueroa et al., 2002; Elston & Fulop, 2002; Diamond & Liddle, 2005; Clarke, 2004; Barnes et al., 2007).

1.6: The research aims and objectives

- The research explores the new participatory spaces that the NDC introduces
- The research examines participatory involvement, and
- It documents the involvement of local citizen's in the participatory governance agenda in delivering the NDC health policy

Initially, the research was to document the participatory governance model that New Labour's policies introduced, whilst measuring the impacts on public health. These

emerging, new, market policies in 1997 had moved from exclusively focusing on individualist approaches with users, to involving the whole community (Popay et al., 2007). The Third Way policies purported to actively enlist citizens in innovative, interactive processes and the deliberative democracy agenda as it emerged, ostensibly to harness community governance while enriching provider partnerships. The new policies were seen potentially as a way of deepening direct community involvement and the data set that emerged provided rich material for analysis.

In 1998, the NDC actors, together with the statutory institutions and policy actors began to create deliberate democratic structures, which are similar to those described by Habermas as highly complex argumentation (Finlayson, 2005; Holub, 1991). It was within this environment in 1999, in the name of '*stakeholder engagement'*, that the focus of the thesis shifted to participatory involvement and spaces as the emerging political context emphasised '*participant involvement*' and '*community empowerment*' alongside the new NDC '*participatory spaces*' that the policy introduced.

1.7: What the research contributes

Public involvement in democratic spaces is widely held to increase social capital, foster social interaction and collective action and stimulate community governance (Putnam, 2000). However, there is a lack of published literature which explores, from the perspective of the local population as lay actors, the development of community governance models, models which were stimulated by the introduction of the NDC regeneration policy. This research brought together both social capital and political discourse, and systematically reviews the operational and strategic activities which arose because of the reconfigured health and social care environment that the NDC policy introduced. The research critically examined the new spaces that the regeneration programme opened up, focusing on the Health Focus Group and the Community Health Action Partnership. It explored social capital discourse, the emerging political economic shifts within New Labour and the impact of centralist, economic policies on community participation.

'*The aim of introducing NDC programmes was initially to ensure greater stakeholder involvement and increased contribution of greater community participation in service delivery.' (NDC Delivery Plan, 2001)*

The research documents and records citizen involvement and participation. Aimed at addressing significant health inequalities by effective partnership, the NDC regeneration programme offered an opportunity for systematic research on the new emerging participatory governance spaces. This qualitative study captures data from the introduction through to the implementation, delivery and closure of the NDC Health Focus Group work and records the unique experiences of front-line workers and local people. The thesis captures the perspectives of a sample of front-line workers and community actors documenting their lived experiences, spanning the decade, giving a previously unheard voice to their views on the implementation and changes on delivery of the NDC within their neighbourhood. The local actors' voices are captured across the 10 year timeline adding to the body of community engagement/participation literature. The research also captures the emerging, complex social welfare networks, documenting the impact that the centralist political context had within neighbourhoods and over time on the NDC participatory spaces.

1.8: The overall conclusions of the analysis

Conclusion 1: The New Labour NDC regeneration policy did successfully engage local social capacity and initially did increase local control over decision-making. Between years 1-3 of the NDC programme, the policy helped to identify the issues and possible solutions and supported greater involvement of the community in decisions related to rebuilding their own community structures. The NDC programme involved local people as key architects, designing their own health services ostensibly to reduce health inequalities and close the health gap.

Conclusion 2: The political discourse under New Labour's Third Way did increase local citizen governance by harnessing social capital between years 1-3 of the NDC programme. However, the impact experienced by the local respondents, along the longitudinal time framework from year 3-4 of the NDC programme, changed with the introduction by the Treasury Department of new policies which conflicted with the activities managed by the Office of the Deputy Prime Minister and the Department of Communities and disrupted community involvement in decisions related to the implementation of the NDC regeneration health focus group programme. The introduction of competing centralising

Treasury policies directly impacted on the NDC programme and democratic citizen participation in a local geographical population.

Conclusion 3: The hoped-for integration of sustained, greater community involvement in health and social services within the community failed.

Conclusion 4: The provision of primary health services became less equitable and New Labour's policies represented a continuation of a neo-liberal market response in order to harness social capital to facilitate capacity, driven by a reduced financial allocation by central government for health and social care services.

Conclusion 5: The NDC Pathfinder experiment partly failed partly succeeded. The direct impact of conflicting, multiple, centralist policies on a local geographical population provided lessons learned for future central and local government and community strategic actors, and for health and social care provision.

This research, from the perspective of the community participants, makes a significant contribution to the existing body of work on community engagement.

2: The Political and Social Policy Context

2.1: Introduction

The objective of the next three chapters (2-4) is to highlight the key attributes of the research environment and to describe the wider political and social context impacting on area-based health initiatives in 1997/8 when New Labour came into government. After 18 years out of power, New Labour was elected with the biggest majority since 1946 (416 seats) (Freedland, 2017, cite The Guardian, 29.4.17: 32-39). The previous Conservative administration had been in government from 1979 to 1997, and the health inequalities were regarded as '*ingrained in the social structure*' (Acheson, 1998: 32). Although the Tory period was marked by substantial economic growth, income differentials had widened with growth of between 60 to 68% within the richer populations and only 10% in the poorest (Acheson, 1998: 32). New Labour inherited a serious health inequalities gap and the Acheson Report identified a range of potential ways to reduce this gap; actions which lay far beyond the remit of the Department of Health, suggesting that a response by the central government as a whole was needed (Acheson, 1998: v). New Labour introduced strategic policies and expanded the funding for multiagency approaches, increasing the active participation of local civil society. Richards (2000) identified that if the top-down approach continued the necessary societal change would not occur, it was also necessary to complement any health reforms the government introduced with a strengthened, bottom-up approach which engaged communities (Richards, 2000: 27). The new government developed the Social Exclusion Unit (SEU) to strategically support the introduction of its integrated neighbourhood renewal and regeneration policies (SEU, 2001).

Here in Chapter 2, changes in the social and political environments from 1997 onward are described and how '*Third Way*' New Labour politics and social capital theory were influenced by the previous neo-liberal politics. I discuss the emergence of a social capital culture, and the old model of community participation, scrutinising how that model changed with the introduction of New Labour policies such as the New Deal Community (NDC) regeneration policy. Chapter 2 ends by highlighting the wider political and social context of democratic participation by communities and the impact the implementation of the New Labour regeneration policies had on participation strategies in an area-based health initiative.

Chapter 3 explores the shifts in health and social care services and the various policy changes that the New Labour government introduced from 1997-2004, specifically the stated purpose and goals of the NDC regeneration policy.

Chapter 4 moves on to consider the changes within health and welfare services management and commissioning introduced by New Labour and the conflicts arising from the reconfiguration of those services. The impact of financial policies introduced by the Treasury and individual government departments related to local authority and health care services on the participation of local actors are also explored.

2.2: The Evolution of the Third Way

Since the mid-1970's Giddens suggested social democracy had been increasingly challenged by the rise in Thatcherism, and what he describes as neo-liberalism had dominated UK public life (Giddens, 1998: 5). Unlike classical social democracy, Giddens (1998) suggested neo-liberalism was hostile towards big government as inhibiting freedom and self-reliance. Thatcher supported these ideas with the addition of her classic, liberal scepticism about the economic role of the state in the market. This neo-liberal hostility was also linked to the Conservative view of civil society as a self-generating mechanism of social solidarity, suggesting civil society would flourish if it was unhampered by state intervention. This neo-liberal thinking saw market forces and traditional institutions, particularly the family, as a functional necessity for social order. The introduction of market-led, economic growth within the welfare system was heralded as maximising economic progress and increasing overall wealth by allowing the '*invisible hand*' of the markets to work. However, Giddens highlighted that tensions arise between free-market philosophies of economic growth coming from the liberation of market forces and more cautious economic conservatism (Giddens, 1998: 11-14).

Whilst Thatcher was considered classically indifferent to inequalities, Major spoke of an intention to create a classless society, arguing that '*a society where the market has free play may create large economic inequalities, but these don't matter as long as people having determination and ability can rise to positions where they can fulfil their capacity*' (Giddens, 1998, p.13). During the 1980s, the Conservative government had promoted the underclass theory alongside the cycle of deprivation as perverse side-effects of welfare dependency '*in order to implement neoliberal policies such as rolling back the provision of welfare and state benefits and focusing upon the family as a*

supportive unit rather than addressing structural or societal causes of inequalities' (Savage, 2015: 355 - 356). The emerging citizens' ideology model of the New Right was rooted in social obligation and a call for active citizenship. This critical citizenship highlighted the inherent differences and similarities between capitalism and democracy, as collective responsibility was eroded under this system in favour of the rhetoric of individualism and consumerism. The Thatcherite language of the notion of citizens as '*deserving and the undeserving poor'* was absorbed into popular consciousness. Throughout the New Right's eighteen years in government (1979-1997), inequalities increased dramatically accompanied by the globalisation of capital and an increased consumerism. Additionally, the ideology of the New Right allowed the government to abrogate responsibility and reduce welfare services, suggesting to the populace that social responsibility was justified and that poverty was a political decision (Ledwith, 1997: 42). Labour won the general election of 1997 with a landslide victory, coming to power during an epoch of globalisation and consumerism that involved domination of world markets by the economies and cultures of the most powerful nation states. This transformation to a multinational, global economy linked the developing countries to the developed countries with an international division of labour (Ledwith, 1997: 94).

2.3: New Labour ideology - the Third Way

The Third Way was the '*big idea*' of 1997-2010 and is generally associated with the writings of Anthony Giddens (1994, 1998, 2000, 2001) and policies shaped by the Democrats within the United States prior to the Labour Party being elected. It was identified as a fresh political beginning in a world that was fundamentally changing (Democratic Leadership Council – Progressive Policy Institute, The New Progressive Declaration. Washington, DC: TLC–PPI, 1996). It quickly became identified with the policies adopted by Blair and New Labour in Britain, which were influenced by Bill Clinton and the Democratic leadership's US policies in the late 1980s (Giddens, 2001). Merkel claimed that the Third Way policies were new and distinctive from both traditional social democracy and from previous neo-liberalism (Merkel, cited in Giddens 2001: 50-52). Alcock also suggested it was how a left-of-centre Labour party should respond to the results of the previous government's neo-liberalism and the effects of market fundamentalism on society (Alcock et al., 2012: 135). Giddens suggested that New Labour's Third Way was a way to renew social democracy as the

impact of globalisation, the emergence of the knowledge economy, and the profound transformational impact of a rise of individualism as economic selfishness or consumerism affected people's lives (Giddens, 2001: 2-4). The extent to which communities, family relationships, norms and values become weakened because people are more individualised and motivated by their own personal goals and aspirations is the subject of a wider sociological debate (Alcock et al., 2012: 168). The focus that New Labour introduced on the fragmentation and differentiation of communities rather than on the way citizens and civil society connect is reflected in the Third Way policies which seek to ensure people are not disadvantaged (SEU, 2001). The Third Way generated a new political language with examples such as, '*tough on crime, tough on the causes of crime', 'full employment'* and *'equality.*' The language of the Third Way was a rhetoric of reconciliation such as '*economic dynamism as well as social justice'* and *'enterprise as well as finances*'. Positive mention of terms such as '*entrepreneurship'* was also introduced together with several core values being proposed which included '*community, opportunity, responsibility, and accountability'*. Blair claimed that his New Labour policies flowed from these values (Alcock et al., 2012: 136). Critics dismissed the Third Way as being vague and amorphous, substituting abstract rules and economic value within '*utility and welfare*' for standards and '*social value'* (Jordan, 2010: 2-4).

Key areas of structural reform that Giddens identified as the characteristic of the Third Way included:

(1) A fundamental theme of Third Way policies was rediscovering an activist role for government and restoring and refurbishing public institutions.

(2) The role of the state is not to dominate either markets or civil society, although it needs to regulate and intervene in both, with the government being strong enough to provide effective steerage for the promotion of social development and social justice.

(3) A critical feature of this New Left thinking was understanding that civil society had a core role to play. The state needed to draw substance from civil society and also to play an active role in regulating it. Civic entrepreneurship was also identified as one of the qualities of a modernised civil society.

(4) New Labour identified a need to construct new social contracts which linked '*rights to responsibility*' and allocated the citizen a right of provision. Third Way policies

suggested key principles of welfare-to-work schemes (DSS, 1998: 21) should include aspects of accepting moral, fiscal and social obligations alongside responsibility (Giddens, 2001: 8).

(5) The pursuit of equality was enshrined at the core of New Labour's Third Way politics with fiscal policy addressing economic redistribution and asset-based egalitarianism related to skills and capabilities in order to contribute to economic efficiency.

(6) New Labour also identified the role of government as central in sustaining and generating a full employment economy.

(7) The Third Way identified the importance of social and economic policy being connected; highlighting the economic efficiency of the working families' tax credit.

(8) To sustain the welfare state, the need for reform of the welfare state was identified and for effective policies designed to cope with societal change. '*Welfare reform in most societies is an absolute necessity if a sustainable welfare state is to be created. For social democrats, of course, the point of reform is not to weaken but to strengthen the welfare state. A 'safety net' welfare system common as envisaged by the liberals is not an option*' (Giddens, 2001: 11).

(9) Active Third Way policies would drive change within anti-crime programmes and reduce rates of violence and property crime.

(10) Governments needed to actively take an interest in ecological risk planning.

Source: (Giddens, 2001: 5-13)

When the Third Way policy narrative was adopted as New Labour's political approach, it was suggested as an answer to the problem of reducing social and economic inequality. New Labour defined equality as '*inclusion*' and inequality as '*exclusion*'. Inclusion refers in its broadest sense to citizenship, to civil and political rights and obligations that all members of society should have, not just formally, but as a reality of their lives. It also refers to opportunities and to involvement in public space (Giddens, 1998: 102-103). The Third Way approach to disenfranchised communities aimed to address their health inequalities by facilitating and stimulating local action within neighbourhoods and communities by increasing citizen participation. It was

suggested that New Labour's social policy would foster individual and collective action, increase participation and shape a new set of relationships within society (Newman, 2001; Leat et al., 1999; Giddens, 1998). The Third Way claimed that central government needed to actively refurbish civil culture to reconstruct everyday civility. Blair argued that this central concept of the Third Way, with its pragmatic approach to policy, was the most likely way to promote values of community accountability and responsibility (Blair, 1998; Porter & Coles, 2011; Marquard, 1998: 27-29). The implication was that these policies would deliver not just a fair society, but also a more effective one (Ham, 1999b).

2.4: Social Capital - Social Capital Theory

The interest in social capital amongst New Labour policymakers predated the 1997 election victory. In 1994, the Labour leader, John Smith, set up the Commission for Social Justice and flagged social capital as one of the elements of the Third Way. The previous approaches to social and economic policy of the '*Old Left*' and the '*New Righ*t' were superseded by the '*middle way*' of '*investors Britain'*. This approach featured in much of the central discourse that became New Labour's manifesto, identifying concepts such as: '*Economic efficiency and social justice are different sides of the same coin; redistributing opportunities rather than just redistributing income; transforming the welfare state from a safety net in times of trouble to a springboard for economic opportunity; welfare should offer a hand up not a hand-out; and the balancing of rights and responsibilities'* (Alcock et al., 2012: 137). Additionally, the Labour Party, when they were in opposition, asked the Commission on Social Justice to review the Parties whole approach to social policy. It was argued that '*the creation of social capital was probably the most pressing question our society faced. Namely how to build solidarity in a secular society exposed to the full rigors of a global market and committed to the principles of individual choice.*' The concept of social capital combining with physical and human capital to enhance individual productivity assumed greater prominence. In a foreword by Blair to the Commission's report he describes social capital as bringing a '*tougher edge to traditional left-wing thought on community, fellowship or fraternity*' and, in 2001, the Office for National Statistics embarked on the research programme designed to inform government policy and encourage the collection of official statistical data on social capital (Field, 2003: 117).

The political scientist Putnam profiled changing trends in civic engagement, social capital and participatory democracy within the American population (Putnam, 2000). One of his central themes since the mid-1990s has been studying Americans' withdrawal from civic life. His work popularised what had previously been obscure terminology, gained the attention of policymakers and a wider public, and influenced social and economic theory. Putnam expanded on his previous Italian study applying his methods to the United States and commented that communities were experiencing a decline in involvement in traditional voluntary organisations. His conclusions related to community involvement and suggested that the more networks a person has access to, the more likely they are to reciprocate the goodwill of others and trust other individuals. Conversely, his argument implies that this generates an internal collaboration between individuals inside of collectives, which, he suggests, develops a more effective democracy with happier and more integrated individuals. Putnam reinforced the term '*social capital*' (Putnam, 2000: 355 – 357) introducing theories of '*bonding social capital*' and '*bridging social capital'*, calling for the renewal of democracy and suggesting this could play a central role in counterbalancing the deterioration within the social fabric of society. Putnam's theory builds on social capital and internalises market mechanisms characterising neo-liberal theory by linking society working together through groups. The work of Ferragina and Arrigoni (2016) explored the distinction between social capital theory, social capital political discourse, and neo-liberalism and their relationships with each other which resulted in the popularisation of social capital within New Labour's Third Way (Ferragina & Arrigoni, 2016: 1-13).

Putnam defined social capital as: '*features of social organisation, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions'* (Field, 2003: 4). Putnam discussed the changing nature of civic and social life in communities and introduced the core concept that social capital could combine physical capital and human capital and enhance individual productivity. Putnam suggests that physical capital refers to physical objects whilst human capital refers to properties of individuals, and that social capital refers to the connections among individuals, such as social networks. Social capital is influenced by the norms of reciprocity and trustworthiness that arise from individuals within social networks (Putnam, 2000: 19). His social capital theory suggested that, in the complex dynamic

of social networks, norms of reciprocity and trustworthiness have intrinsic value. In 2002, Putnam's influence on the Bush administration was noted by one of Blair's think tanks - the Performance and Innovation Unit (PIU) (Blair, 2002: 50).

In identifying the theory of social capital, Field (2003) simplistically summed it up in two words: '*relationships matter'*. People working together to achieve things may share a common set of values, and they connect and work through a series of networks, and, to the extent that these networks constitute a resource, they can be seen as forming a kind of capital (Field, 2003: 1). Field described the work of the social theorist, De Tocqueville (1832), as underpinning American democracy and economic strength and providing the social glue that helps to bond individuals. Field reflected (in a critique of Emile Durkheim's work) on the transition of solidarity and the impact of 19th-century capitalism (Field, 2003: 138). As a social science concept, social capital assumed greater prominence with what was seen as the excessive individualism of policymakers in the Reagan and Thatcher years, when Margaret Thatcher proclaimed *'there is no such thing as society'* and as more individualistic interpretations emerged (Ledwith, 1997: 42). Rediscovery of society, the decline of community and the emergence of social capital theory was further popularised within the political discourse in the 1990s by the Third Way. New Labour linked policy and social capital theory within its welfare, neighbourhood and education reforms and attempted to create social capital with empowered families and communities (Ferragina, et al., 2016: 5).

Social capital began as a relatively simple concept with the original conceptualisations, as developed by Bourdieu, Coleman and Putnam (Field, 2003: 136) being stretched, as the debate related to social capital theory exposed some of the ways in which social ties can be activated to produce positive benefits or negative outcomes that reinforce inequality (Field, 2003: 136-8). According to Putnam, the least transferable dimension of social capital is trust. However, Field argues that trust is a product of social capital not one of its components. He suggests the main reason the policymakers are so enthusiastic about social capital is because it translated social involvement into an economic measurable, as policy makers wanted to harness social capital to support an economic deficit by using people. The evolving concepts of social capital had previously been explained by Putnam's benevolent view that when people are collectively engaged in a network then the social fabric is strengthened. However, this

was challenged by Bourdieu, who suggests that, rather than seeing social networks generally benefiting society, they had continued to allow the privileged and powerful to use their connections to help each other and protect their interests (Savage, 2015: 131-3). Beresford (1999) suggests citizens, within social networks, experiencing inequality or poverty are products of human agency and the institutions involved in both shaping and interpretation. Whilst politicians and academics may have overlaps, their perceptions are neither homogenous nor monolithic. There is also conflict, cooperation and interaction with broader economics and geopolitical forces (Beresford, 1999: 5-7).

Between 1993 and 2000, the debate around social capital suggested that by supporting civic engagement, the public sector could provide solutions to the problems created by economic decline and the impact of globalisation. Political discourse on the global economic crisis reconciled individualism, social interaction and collectives (Coleman, 1988). Greater social engagement was adopted alongside an increasing European and transatlantic rise in political favour for neo-liberalist theory (Bourdieu, 2005; Ferragina, et al., 2016: 1-13).

The Labour government introduced their neighbourhood renewal and regeneration policies as part of its Third Way ideology heralded by Giddens (1998) as a rational response to the new political social and economic environment; at their heart was a belief in the value of community and commitment to equality of opportunity. The neighbourhood renewal strategies (NRS), including the New Deal for Communities programme (NDC), were central state policies aimed at increased partnership with civil society, with the emphasis upon ‘capacity building’ (Diamond & Liddle, 2005: 124). The intended outcomes of increased partnerships and joined-up working were to harness an increased participatory involvement of both the health and social care workforces to strengthen them and to reduce inequalities in local communities (Diamond & Liddle, 2005: 94-103). New Labour’s Third Way regeneration policies, introduced in 1997, were intended to stimulate democratic participation, and were based on the belief that people collectively who engaged in extensive social networks would strengthen the social fabric, with lay actors finding local neighbourhood solutions which would foster improved health and well-being (Giddens, 2001: 38-39). These new regeneration policies and enhanced funding also introduced additional contractual obligations for monitoring targets and coding outcome measures, which in

turn, inevitably increased regulation. Jordan (2005) highlighted many pertinent issues for this research to scrutinise, around the marketisation of health and social care and the Third Way approach to services, which he sees as being '*consumed*' by individuals. He argued that the Third Way not only introduced increased monitoring into social care systems, it also placed an economic metric on '*social value*' (Jordan, 2010: 178).

Jordan suggested the Third Way's programme had largely involved substituting systems which deal in abstract rules and economic values for ones which deal in specific, interpersonal, negotiated standards and creating '*social value*'; the social value which is distributed through human interactions. The Third Way's involvement in public policy was the expansion of markets and market-orientated reasoning into what had previously been spheres of life traditionally operating by nonmarket norms. Cultural and moral regulation, he suggests, relies on inter-subjective communications and accountability between members of a community. However, the Third Way policies established a regime based almost exclusively on contractual regulations and obligations inside health, education and social welfare, introducing economic values and creating 'social value' (well-being). Jordan suggested this introduced widespread contractual regulation into previously differently regulated spheres of activity (Jordan, 2010: 4).

2.5: The wider policy environment

The NDC programme was launched in 1998 as part of the government's national strategy for neighbourhood renewal (SEU, 1998). In 2001, New Labour introduced the Neighbourhood Renewal Unit (NRU) which was heralded as responsible for overseeing the comprehensive, government, neighbourhood-renewal strategies and directly responding to local circumstances. The intention was that the Neighbourhood Renewal (NR) strategy would harness the expenditure and spending by various different government departments and support the coordination of a range of different programmes established to pilot new ways to tackle deprivation in the poorest communities in England (DoH, 2002: 4). The Neighbourhood Renewal Fund (NRF) provided £900 million additional non-ring-fenced resources over 2001 to 2004 to 88 local authorities in the most deprived areas to support greater collaboration with local strategic partnerships (DoH, 2002: 10).

2.6: The purpose of the NDC policy

In 1997, the Blair government developed the New Deal for Communities (NDC) as part of its neighbourhood renewal strategies (NRS). The New Deal for Communities programmes were introduced into area-based initiatives (ABIs) to support intensive ten-year regeneration strategies in 39 of the poorest neighbourhoods. They were intended to bring mainstream providers and local stakeholders together to tackle neighbourhood problems in an intensive coordinated way (DOH, 2002: 10). The national strategy for neighbourhood renewal identified its approach as delivering services within targeted, area-based initiatives with spending linked, whilst making communities more directly involved in identifying and solving their local problems (DOH, 2002: 14). From 1997-2010, New Labour's NDC regeneration policy focused on health and social care delivery from the perspective of encouraging enhanced partnerships with the local actors. This research analyses the implementation of the New Deal for Communities regeneration policy, introduced in 1998 (SEU, 1998), and analyses how this policy was experienced by the front-line workers and local people within an area-based initiative and how these local actors participated in the delivery of the programme. The Joseph Rowntree Foundation Report '*Community Participation - who benefits?*' (Skidmore et al., 2006) explored whether policies to involve people in making decisions about their own new political narrative converged on community and built effective, strong social networks. The report highlighted community development in governance as a solution to 21st-century public administration. They also explored if policies to promote community participation in governance actually build social capital (Skidmore, et al., 2006: 3). Policymakers were interested in understanding the kinds of social networks enable citizens and communities to access resources so that they can work together to tackle problems for themselves. Policymakers identified these as particularly valuable strategies within disadvantaged communities who do not possess formal economic power in the way that more affluent communities do. Skidmore suggests social capital is attractive to policymakers because it holds the possibility of improving social outcomes more effectively and more economically than traditional public services alone (Skidmore et al., 2006: 4).

According to Diamond & Liddle (2005: 8), the NDC regeneration policy intended to introduce a new model of working and additional resources into geographical areas selected on some key underlying principles. The NDC was a ten-year strategic

transformation of specifically identified disadvantaged neighbourhoods which used community engagement, placed the community at its heart; cultivated a partnership approach and stimulated learning and innovation. Thirty-nine partnerships were established each of which received about £50m over ten years (Fordham, 2010). New Labour attempted to establish a clear differential between the NDC and the previous approaches to regeneration by establishing the underlying key principle that the physical and social renewal had to be developed *with* local communities. This represented a significant shift from previous thinking and practice in the design, delivery and management of regeneration (Diamond & Liddle, 2005: ix).

Opportunities for greater engagement and community participation in implementing these New Labour policies assumed the creation of social capital from which the community benefits. Planning the policy implementation assumed enough people wanted to participate because the structures of engagement were embedded in the everyday spaces of community life, and their informal social networks. Skidmore et al.'s (2006) work suggests that if we want to create social capital through community participation, it is not enough to just create new structures of engagement without regarding whether anyone will actually want to bother using them. '*We need to pay attention to the relationship between community participation and the formal structures of local governance and the broader arrays of community size and perceptions*.' (Skidmore et al., 2006: 7)

The central focus of my research is the context of the new, '*joined-up'*, social and political policy discourse that emerged with the introduction of modernisation under New Labour's Third Way (Ledwith & Springett, 2010: 45-50; Jordon, 2010: 144) over the longitudinal framework 1997 – 2010. The research explores whether these policies are less aimed at increased local community engagement and more a continuation of the previous Conservative government's neo-liberal policy and New Labours attempt to introduce a competitive market economy for health services rather than increasing local community engagement. The rest of this chapter explores specifically the development of citizen participation and community governance under the Third Way.

2.7: Personal perspectives and community engagement

My research scrutinises social capacity, community participation and participatory democracy before the introduction of New Labour's NDC policies. It establishes the

parameters of the research environment post-1998 and critically explores how citizen participation and community governance changed with the new social and political frameworks. This overview of citizen involvement in participatory health policies, the changing political discourse and the resultant impact of these changes on civil society (Ledwith & Springett, 2010: 171-175; Figueroa et al., 2002) contributes to the wider context of the research thesis.

This critical dialogue of the social and political policies contributes to an analysis of how New Labour's Third Way policies and the delivery of the New Deal for Communities' regeneration programme impacted on participation in health care in an area-based health initiative. The chosen research and the method of enquiry are rooted in my prior personal experience and involvement of working in health programmes in deprived areas, as outlined in Chapter 1.1 and my conviction that people have a right to a greater say in their lives, services and neighbourhoods.

2.8: Community development pre-1997

As a public health clinician since the mid-1970s, prior to this NDC regeneration programme, I had opportunities to explore the importance of community development and participatory working that directly involved local actors (Ledwith & Springett, 2010: 13-30). As a clinical worker, I experienced my operational colleague's interpretation and understanding of actively involving communities (Macaulay et al., 1999: 774-778; Popay, 2006: 571-572; Pickin, 2001). I also experienced community as a space for critical pedagogy, an environment to understand the dynamics of participatory democracy and learned the importance of working with citizens to develop their own solutions to the problems that affect their lives (Ledwith, 199: 139). I experienced first-hand within local and area neighbourhoods the direct impact of social deprivation and poverty on individuals and communities, an impact that was not acknowledged politically or interpreted into policy until a decade later (Townsend & Davidson, 1982), when social policy discourse began to link the welfare state, education and the environment to the economic costs related to disease (Fraser, 1984: 177-206). The correlations between health inequalities, life expectancy and the impact on health and welfare services were not widely discussed in the public domain until the early 1990's. Whilst the Conservative government had commissioned the Black Report in 1979, the findings were not published as public policy until a decade and a half later, when an

investigation into the findings on health inequalities was re-commissioned. The Acheson Review (1998) was published and widely distributed by the New Labour government and its recommendations used to influence the investment in participatory governance and social capital policy (Skidmore et al., 2006: xv).

The early health innovators who identified the causal relationships between systems theory, community capacity and public health gains influenced my involvement in the evolving community development agenda. In the mid-1970s, studying as a clinical, public health community specialist, I encountered the work of the anthropologist, Margaret Mead (Mead, 1901-1970). This was my first introduction to her anthropological insights and the theoretical frameworks which identified the constructs that impact on family life and human society. In the 1970s people started to be operationally employed as specialist community development workers in geographical areas with high levels of poverty and health deprivation as part of a state intervention to harness local communities. In 1975, when I first began working within communities, I had the opportunity to practically experience the complex dynamics which impact on communities when practicing as a health visitor in a deprived neighbourhood on the outskirts of Liverpool. It was at this time that I came across innovators, such as Jennie Popay (Popay, 1996: 6-14) who explored social inequalities, public and community engagement in health decision-making and evaluated complex social interventions which harness and involve lay communities and community workers (Popay et al., 2003: 1-23).

Identifying a gap for future research, Popay suggested '*we explore at a conceptual level the role lay knowledge may play in mediating the relationship between structural inequalities, individual or group action and health status. Lay knowledge rooted in the places that people spend their lives, has theoretical significance for understanding of the causes of health inequality. A second essentially political argument is that lay knowledge represents a privileged form of expertise about inequalities in health which may pose a challenge for those who claim the status of either researcher or policy expert in this field'* (MacKian et al., 2003: 219-229).

I started exploring operationally and strategically the relationship between health improvement, community action and the impact of policies aimed at improving population health. In 1997 when I began working within the research area-based

initiative, Dr Chrissie Pickin was the Director of Public Health for the geographical area and both she and Popay were involved in on-going research work into regeneration and community health (Popay, 1996; Pickin et al., 2002). These geographical public health initiatives influenced my approach and supported the underlying importance of maximising community and lay involvement based on mutually respectful partnerships, strengthened by trust, joint activity development and working together. The NDC regeneration policy focused on enabling communities to have greater control (Batty & Cole, 2010: 17-37) and used concepts of community development, participation and engagement in local neighbourhoods (Stafford et al., 2008).

In an effort to enable communities to have greater control, local governance was initially explored as interacting to develop health improvement solutions within local populations. In this early context, '*community development*' meant working within social networks, relating to cogent human values of trust and reciprocity, and developing effective social interaction and relationships on a one-to-one basis. This community development focused on participation and self-help in area-based initiatives. In the 1970s I worked with a variety of public sector workers such as health visitors, social workers and probation officers who had begun engaging with people and adopting these community, development-based approaches. Prior to this time, community development workers had been generally located within Public Health Departments working with communities' civic and social networks to address the health needs of the local population (Savage, 2015).

My early experiences working directly on a one-to-one basis with individuals and also within small, peer-group/neighbourhood collectives, helped develop my understanding of the links between community participation in governance and social capital. I experienced the challenge of community development within deprived communities, the necessary interfaces between state and society to build community capacity and the impact of the wider local community infrastructure on health (Cornwall et al., 2004: 1-6; Ledwith, 2010: 50-54). These experiences as a clinician gave me a grounding and broader understanding of the dynamics and concepts of involving people and linking social capital and what specific demographics affected levels of participation, including socio-economic status. Initially, as a clinician and as a social scientist, I became familiar with participatory health-promoting practices targeted at enhancing

resilience, specifically within disadvantaged communities to enable transformation (Ledwith & Springett, 2010: 171-189). I explored the concepts of self-empowerment and promoting environments where individuals can increase their own capacity and solve their own problems. An emerging theme for policymakers was influencing community cohesion and deprivation in neighbourhoods through community participation policies; however, formal links between active participants, and the public institutions to build social capital were necessary. My experience was that the value of social capital to individuals, groups or wider communities depends on whether they are able to access it. A local authority who wants to work with a particular sector may choose to build a limited number of good relationships with a few. Giving just a few individuals or organisations access to particular forums means that social capital is neither brokered equitably nor distributed evenly (Skidmore et al., 2006: 10-12). Bridging and linking social capital and engagement of the local actors in order to capture strategic, sustainable, empirical, health improvement outcomes was only partially successful during my early work within this field.

Successful community development in any context '*needs to be framed within participatory democracy, a worldview in which communities are in control of the decision-making processes that affect their lives, giving voice to the most marginalised, giving greater power to local governance to influence policy-making thereby making institutions accountable'* (Ledwith & Springett, 2010: 15).

Whilst Putnam had described the importance of reciprocity, connected communities and social networks having innate value and affecting the productivity of individuals and groups in society (Putnam, 2000: 134-147), a frequent problem I encountered was that local actors experienced poor or inadequate access to the democratic spaces that enabled their meaningful participation at the reflection - action praxis. The model of praxis is intended to locate the local action within this wider structural analysis (Ledwith, 1997: 141).

In the early 1980s, my work involved HIV/AIDS activism, social movements and coordinating the actors affected by the virus and the emerging community and clinical responses. Whilst working in the World Health Organisation in 1983-1987 on the Multi-City Action Plan HIV/Drugs programme, I coordinated activities in sixteen European member cities to help facilitate participation from local communities in designing their

health programmes. This involved coordinating and communicating with the non-government organisations, voluntary and statutory sector, civil society, politicians and global policymakers. I positioned people affected by HIV and AIDS central to these discourses and practices. I explored models of community development and the relationship with formal structures of local governance and the resulting benefit that those collectives delivered to help ameliorate any adverse impact on health and social care systems to improve outcomes for people living with HIV (Buve et al., 2003: 41-51). The communities affected drove the solutions, with the voluntary and statutory agencies participating with the key affected actors who, in most instances, willingly became involved. Part of my learning involved how to effectively create the spaces to maximise engagement, support the interactions between individuals across complex systems, evaluate multi-layered networks and develop agency in the evolving policy environment (Cornwall et al., 2004: 2; Cornwall & Schattan Coelho, 2007: 1-32). A primary focus of the programme was for the HIV community, voluntary and statutory agencies and politicians to establish decentralized, interlinked health and social care networks. These new networks necessitated coordinating and engendering complex new participative partnerships that stimulated change and reform inside the existing bureaucratic systems (Macaulay et al., 1999: 774-778).

The New Deal for Communities area-based initiative introduced in 1997 gave the opportunity for new participatory frameworks. How the various social networks formed, evolved and responded to the influences of the social, political and economic changes under the NDC are explored from the local actor's perspective (Lawless, 2007: 2-3). Diamond & Liddle (2005) describe how learning from effective policy is usually conducted by policy experts, and the value of critical reflection from the local respondents is often omitted from that learning (Diamond & Liddle, 2010: 20-21).

Bissessar (2010) highlighted the importance of transferable learning and she compares similar mechanisms to learn from the introduction of the New Labour regeneration policies, commenting on the internal pressures for change and the role of nation states, local government, community and partners (Bissessar, 2010). Diamond & Liddle (2005) document the critical importance of front-line workers in building informal relationships and trust, in order to give citizens more control over the services delivered in their neighbourhood. Front-line workers, together with the local

citizens, need to be directly responsible for developing robust engagement strategies which enable both the local and strategic actors to achieve intercommunity co-operation, social cohesion and transformational change (Ledwith, 1997: 118). The insight needed by strategic actors, to act effectively together with local actors within their own individual worlds to create changes, required health workers to work both vertically (towards their local and central government directors) and horizontally (across the various public sectors and community actors) within the participatory democratic spaces that emerged. This thesis explores these aspects further in Chapter 4 and in the analysis chapters 6, 7 and 8.

The thesis research focuses on the opinions and voices of the clinical front-line health workforce and captures their thoughts on participation inside this evolving paradigm. As Ledwith (1997: 109-115) discussed, the embodiment of successful participation and empowerment for a collective movement for change requires and involves greater links with all the actors across different paradigms and cultures. I learnt that for sustainable transformation it was important to systematically involve all the community actors across a range of operational, tactical and strategic networks.

Putnam has suggested '*social trust is strongly associated with many other forms of civic engagement and social capital. Other things being equal, people that trust their fellow citizens, volunteer more often, contribute more to charity, participate more often in politics and community organisations, also volunteer on juries, give blood more frequently, comply more fully with the tax obligations, and are more tolerant of minority views, and display many other forms of civic virtue. In that sense, honesty, civic engagement, and social trust are mutually reinforcing'* (Putnam, 2000: 137-139).

With the delivery of the NDC programme, I developed a rich or 'high trust' culture which flourished across and within the development of the spaces and the delivery of the health projects. (Figures 2.1 and 2.2). I was cognisant of the importance of developing a high trust culture, and of stimulating and supporting volunteerism and community involvement. How these factors impacted on the delivery of the NDC policy and NDC's successes and failures is explored from the perspective of the various respondents.

Figure 2.1: Relationships and the Trust Dynamic

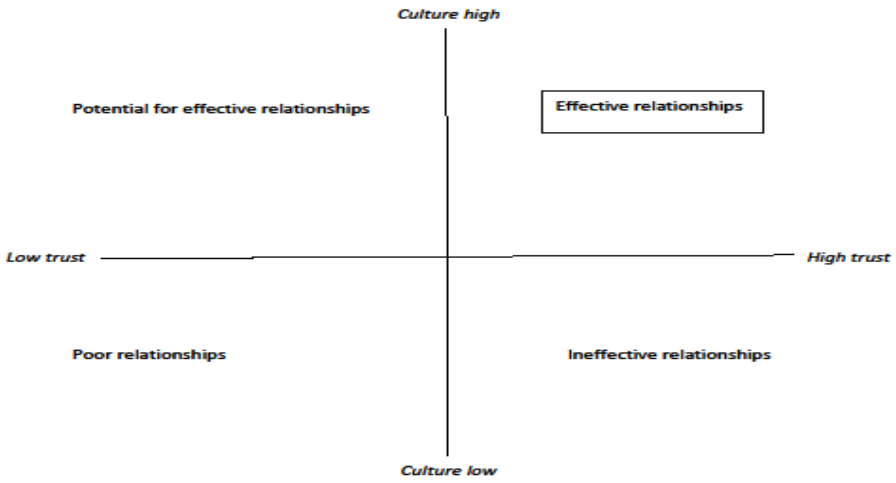
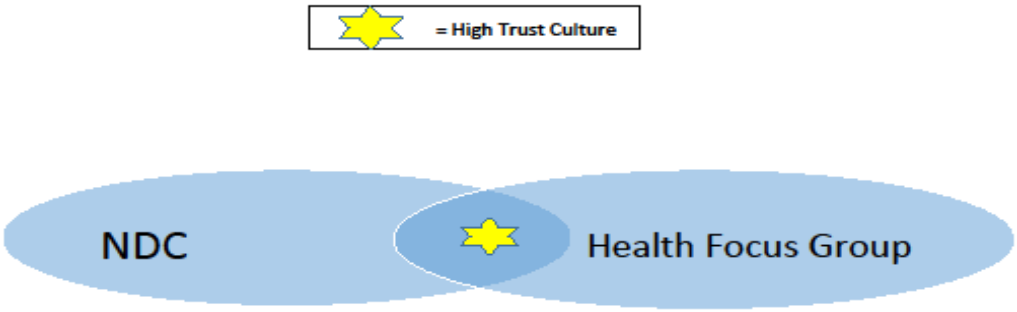


Figure 2.2: Location of the developing culture of enhanced trust in NDC area-based programme



2.9: Community development post-1997

This section documents the research-generated knowledge related to the local actors' views and experiences of involvement and participation within the NDC regeneration, area-based initiative introduced in 1998. As a Health Development Manager working inside an area-based initiative, I consciously explored the connections between the micro-participatory social spaces, which local actors directly experienced and the

macro-political spaces which impacted on the same respondents' lives. The new community engagement strategies emerging with the introduction of the New Labour health policies were markedly different from those experienced in the 70s and 80s. Tony Blair began preparing these new policies when he became the leader of the Labour Party in 1995, prior to election in 1997, as discussed earlier in this chapter (Pratchett, 1999; Giddens, 1998; Finlayson, 2003). The focus of the NDC participatory policies involved collectives working in area-based initiatives. Additionally, with the intention of increasing local decision making, new roles and responsibilities were outlined in 2001 by the Department of Health, which shifted more power to the operational front line health care workforce, which impacted on the professionals working within regeneration; this is explored further in Chapter 4 (DOH, 2001).

The research scrutinises the implementation of the New Labour, neighbourhood-regeneration policies that stipulated the need for individuals to lead the change process, and to facilitate community participation and citizen involvement in partnership across the employment, education and health sectors. It also documents across a time period the changes in the active involvement and capacity-building of local communities as partners in the decision-making processes in neighbourhood regeneration. Beresford (2016) discusses practices changing because of the introduction of broader policy which necessitates that key actors, including politicians and senior managers, need to be engaged with these change processes, if change is to be achieved. He highlights the helpful distinction between two forms of change identifying: incremental change within the system, and radical change – changing the system itself. He suggests that policymakers and services focus on form (Beresford, 2016: 338).

2.10: Capacity building

A recurrent theme within the NDC was enabling the local community to participate as equal partners within the regeneration programme. A central presumption was that the professionals and agencies working within the regeneration field would modify their working practices to include the active participation of local citizens (Diamond & Liddle, 2005: 3-4). This premise raises fundamental questions, such as:

- At what point do the community become involved in decision making?
- What skills, training and support are needed? and

- Is a community identified as individuals or as a collective, decision-making group?

The Third Way ostensibly produced an opportunity for communities to work together as a collective, and to offer consensus opinions that could direct the governance of the NDC partnership board. The developing social capital theory provided the theoretical framework that superseded the older notions of community development (Skidmore et al., 2006: 8-10). The New Deal for Communities and Health Action Zone policy frameworks introduced a complex set of new structures as to how these policies were to be operationalized in the regions and local areas (Fordman, 2010). In these new emerging public spaces both the constraints and the opportunities to establishing democratic and economic partnerships are captured and critically examined in this thesis. The scrutiny of these democratic spaces and the influence of local actors as the solution to the health inequalities in an area based initiative (ABI) is a core activity of the research thesis. I discuss the respondents' experiences further in the body of the analysis of the research in Chapters 6, 7 and 8.

2.11: Linking knowledge, human agency and social structure

Within the NDC framework, the pre-1997 terms '*community*' '*community development*' '*empowerment*' and '*active citizenship'* were legitimised and deflected the politics of social responsibility. Empowerment and active citizenship became seen politically as a way of loading social responsibilities onto the family, on the individual and on the community (Ledwith, 1997: 148). The concept of community work had been adopted within neighbourhoods, however, the inequality identified between populations continued to rise (Acheson, 1998: 8). The published literature on health inequalities failed to adequately address the causal relationship between human agency and social structure or offer the contributions from the lived experience of lay actors (Popay et al., 2007: 972-977). It was the Minister for Public Health in 1997, Tessa Jowell, who identified that '*in light of the evidence and within the framework of the government overall financial strategy – to review and identify priority areas for action and policy development, while the scientific and expert evidence indicated this is likely to offer opportunities for government to develop beneficial cost-effective and affordable interventions to reduce health inequalities*' (quoted in Acheson, 1998: 155). New Labour's Third Way introduced centralist policies to tackle health inequalities

concentrating on the widening '*health gap'*. This research interrogates the way New Labour's policies involved people in making decisions about public services, reviews the democratic dialogue and examines the views from the respondents' transcripts as the NDC programme evolved between 1999 and 2007. The New Deal for Communities programme was politically heralded as one of the most important, area-based initiatives launched in England. It was purposefully introduced '*to reduce the gap between some of the poorest neighbourhoods and the rest of the country'* (DCLG, 2010c; Lawless, 2007), and local people were encouraged to participate within a '*place*' based approach. The data analysis questions whether a focus on social capital actually fostered greater collective action within the community health spaces.

Scott suggested that the way society and the environment have been refashioned by state intervention with political ideologies, particularly the impact on urban order '*place*' and society, has no necessary relationship to the urban order as it is experienced by the local citizens (Scott, 1998). Physical spaces and places for meeting in collectives for developing reciprocity within neighbourhoods designed by city planners are not necessarily or always a suitable space for local residents.

'*The fact that such order works for the municipal and state authorities in administering the city is no guarantee that it works for citizens. Provisionally, then we must remain agnostic about the relationship between formal spatial order and social experience*' (Scott, 1998: 58).

This chapter explores how the Third Way paid attention to and criticised the adverse impact of individualisation on modern life pre-1997 and suggests that building or maintaining a sense of community and social cohesion would ease existing conditions of social fragmentation and social inequality (Giddens, 1998: 319-320). In a society working towards transformative change, Ledwith suggested that critical debate is the essence of participation and empowerment (Ledwith, 1997: 148). She identified that collectives can only achieve transformation if a community works to develop a coherent, theoretical base faction, which in turn can only come about if the critical praxis bridges the divide between theory and action (Ledwith, 1997:136). Stafford et al. (2008) suggested, after evaluating the impact of the NDC in relation to tackling inequalities, that participation would best be targeted amongst residents within the lower education, lower income ranges. Skidmore et al. (2006: xi) identified that

community participation tended to be dominated by small groups of insiders who were disproportionally involved in large numbers of the government's activities. In the body of the thesis, I explore this further.

2.12: Civil Society and democracy

Coleman (1988) identified social structural conditions, and rational and purposeful actions inside the social context, as they account for the actions of individuals and the development of social collectives and introduced the concept of '*social capital*'. Influenced by Putnam (2010), this chapter acknowledges that New Labour introduced the suggestion of exploring participatory spaces, where people could come together linking community development and social capital to harness community capacity, potentially releasing financial resources and enabling their increased contribution to the local welfare economy. The introduction of the NDC programme allowed the possibility of these new participatory spaces, in which people could come together to advance their health and social care interests, to be researched and explored. The Third Way and the neighbourhood renewal policies gave permission for the establishment of the new NDC health forums overseeing the health and welfare agenda locally and for the NDC boards to co-opt local citizens and strengthen local governance. The NDC policies encouraged local front-line workers and local citizens to become part of the spaces for collective action and co-operative working. It was inside these new, social-welfare spaces that the local actors used participatory collective action and shared power to enable them to arrive at a shared consensus agreement on the NDC ten-year plans. My research examines the evolving consensus, models of local governance and the opinions and views of local actors related to their involvement in developing the NDC health programme. The NDC regeneration policy introduced a complex system of networked actors with the potential and capacity to shape and influence social, economic and environmental changes (Chesters, 2009: 209-212). If the voice of the local actor is ignored, a lack of ownership or control alienates citizens from the process, and the eventual outcomes. The policy intended to transform neighbourhoods using community engagement, a partnership approach and learning in order to tackle health inequality (DoH, 2001). However, Skidmore's research (2006) suggested that community participation in governance only mobilises a small number of people, and a strategy is needed to maximise the value from the existing small group which involves mobilising

participation and embedding this collective participation into a wider community life. My research thesis acknowledges that developing partnerships within the health and well-being arena involves working within complex and adaptive networks and multi-layer governance, and with some parts of the system being interdependent on other parts this can result in unintended consequences in another unrelated space (Popay & Williams, 1998b: 32-37). Awarding NDC regeneration funding assumes that the population living in the area-based initiative have experienced inequalities and multiple deprivations, and that the NDC programme with '*a participative approach would help to overcome these problems and make services more responsive to local need'* (CLG, 2005). The introduction of policies which stipulate a participatory approach presents a fundamental challenge to reforming democratic decision-making as it involves acknowledging values of citizen participation, deliberation and empowerment by administrations and agencies (Fung, 2001: 5). Whilst the Third Way approach was being advocated by central government in the late 1990s, there was also a renewed focus on '*democracy*', concentrating on community development and citizen participation. The popularisation of language such as '*civil society*' was being used to refer to '*the arena in which people come together to advance interests that they hold in common, not for political power or profit but because they care enough about something to take collective action'* (Edwards & Gaventa, 2001: 2-3). Shifts in thinking which highlighted civil society within a new diplomacy also introduced '*global governance'* with rules, norms and institutions that govern public and private behaviour across national boundaries that Edwards suggested were changing; as economic and cultural globalisation progressed the state's monopoly of governance was challenged. Gaventa (2006a) proposed that despite efforts from the Labour Party to call for new forms of '*active citizenship*' and the '*new localism*' that could revitalise democracy, people were becoming increasingly frustrated and the political process was becoming less democratic (Gaventa 2006a: 264-264). The Neighbourhood Renewal Unit (NRU) focused on developing a more substantive empowered citizen participation in the political process. However, this raises issues related to greater involvement of community leaders, voluntary groups, neighbourhood residents and civic associations in the policy decisions which affect their lives and in the design of the implementation of services, particularly at a local level. Gaventa (2004), in a report commissioned by the NRU argued that enhancing the involvement of local actors and deepening democratic participation and community development approaches would help more

effective neighbourhood renewal. However, he suggested that these new participatory approaches would weaken the role of local governments and the responsibilities of the elected members councillors and representatives (Gaventa, 2004: 6-7). Gaventa (2006a) explores the citizen participation debate, arguing that democracy is in crisis and that there is a need to support a political process of focusing on '*deepening democracy*' with decentralisation, while promoting new visions and practices to strengthen full-system engagement. He maintained that democracy is in crisis, despite the Labour Party's efforts towards active citizenship and new localism. He proposed the introduction and opening up of new, participatory, democratic spaces at a local level.

'*Democracy building is an on-going process and struggle rather than the adoption of a standard recipe of institutionalised design. Democracy building work for the next century involves going beyond current formulations to find and promote those new and emerging visions and movements for democracy which will extend and deepen its meaning and practices towards full citizen engagement, especially in terms of how citizens engage with these new democratic spaces, and how such participation delivers on meeting basic developmental and social needs'* (Gaventa, 2006b: 8).

The NDC offered a space for transformational change involving local civil society which required involving wider partners in the decision-making process. Previously, autonomous decisions had been taken by clinicians. Ledwith and Springett (2010: 59-62) suggested that participatory practice had been an important catalyst for transformative, community involvement and that central governments had been modelling community development since the mid-1960s. However, the introduction of the New Labour's regeneration policies saw a radical paradigm shift as community participation shifted its focus to harnessing social capacity within the localism agenda.

Newman highlighted the sharp conflicts in the participatory politics of New Labour as it attempted to displace issues of poverty and inequality by a new, more contained, but unmanageable set of distinctions based on the idea of social exclusion and inclusion (Newman, 2001: 158). With the government's shift in emphasis to social obligation rather than social rights, in 1998 Tony Blair announced the introduction of the Social Inclusion Unit as part of his Cabinet Office's commitment to the introduction of social inclusion policies that moved towards greater integration and empowerment of

communities, based on the premise that this would encourage institutions and individuals to engage in constructive cooperation and partnerships, rather than competing with one another (Blair, 2001). Since Tony Blair's election as Labour Party leader in 1994, Giddens, a major architect of this new ideology, acknowledged the impact of globalisation and suggested that the Third Way was not driven by political opportunism, but was a rational response to the changing world, and to the new economic (Terry, 1996; Baum, 2000), political and social environment (Giddens, 1998; Giddens, 2000).

2.13: Conclusions

In this Chapter, I introduced the Third Way and the changing civil order, new democratic spaces and local participation that emerged under New Labour. I acknowledged the changes in the social-care infrastructure with the introduction of internal market mechanisms locally. The chapter then focuses on social capital, since as the context for the research thesis is to examine the individual local actor's view on how and why they participated locally and what they thought they achieved in the longitudinal delivery of the NDC health agenda. The introduction of the NDC regeneration research offered the opportunity to collect the local actors' opinions sequentially and synergistically. The research data offered a unique insight and understanding of both the participatory spaces and the impact on the local actors as they participated in designing and implementing the NDC health programme. In this chapter I have scrutinised how the metric of community development and participatory engagement changed with the introduction of New Labour policies in 1997. In Chapters 3 and 4 the thesis examines further how factors such as globalisation and NHS finance pressures increased the necessity to introduce mixed economies of care and acknowledges the rapidly changed health and welfare infrastructure. The research thesis concentrates across the longitudinal 1997-2007 timeline when regeneration NDC policies were introduced alongside the new Public Finance Initiative policies introduced by the Treasury department into the NHS. In Chapters 6, 7 and 8, the research thesis explores further the respondent's views on leadership, management and their representation on the NDC partnership board and participation in decisions.

3: Health Policy Framework

3.1: Introduction

This chapter examines the environment that the Third Way NDC regeneration health policies were introduced into. It acknowledges the historic welfare legacy and examines the introduction of the new regeneration policies against the background of the changes in the internal health market that the Conservative government had established. New Labour introduced restructuring changes to the National Health Service (NHS) and Local Authority (LA). These changes represented an extended break from the familiar delivery structures in health care, and opened up the possibilities for individual actors, either employees or service users, to make choices and exert influence (MacKian et al., 2003: 220). The research examines how these were received and how they impacted on the new participatory, public health agenda. I explore how the NDC regeneration policy changes affected a wide range of actors and activities by involving a variety of different agencies, including crime and disorder, education, local businesses, employees and community groups and by encouraging partnership working. The introduction of the NHS plan recognised the '*outdated*' provision and established a goal of building partnerships and harnessing social capital to enable the transformation of health services (DOH, 2000). A reoccurring concept in New Labour's regeneration policies was the concept of stimulating public health '*partnerships*' which were aimed at tackling health inequalities; '*Partnership working is now a mainstream activity for local government and the NHS'* (DOH, 2001: 2). New Labour's policy agenda advocated the development of partnerships across communities, sectors and the state, to facilitate interagency partners working around a '*social model*' of public health (DOH, 2000: 70).

This chapter acknowledges both the welfare state's existing historical structures and their legacy as they impacted on New Labour's reorganisation of health and social care services which was intended to encourage and engender a '*joined up management'* and citizen-involvement agenda post-1997 (Darlowet al., 2007: 117-118). It considers the complex, emerging NHS health and local authority (LA) social care infrastructure changes as New Labour came into central government. It discusses partnership working within welfare and health systems and whether health policy did introduce greater participatory democracy or was it an aspiration or rhetoric used to

deflect attention away from material and structural issues. It identifies the previous divisions in service delivery, the financial constraints, the increasing health inequalities and the role of citizens in the welfare state prior to 1997. Chapter 3 sets the context of participatory democracy in the UK as related to health regeneration. It also acknowledges the dichotomy that the responsibility for the programme was positioned within different departments of government and this further resulted in difficulties in developing strong governance relationships with local actors and community governance (Diamond & Liddle, 2010: 189).

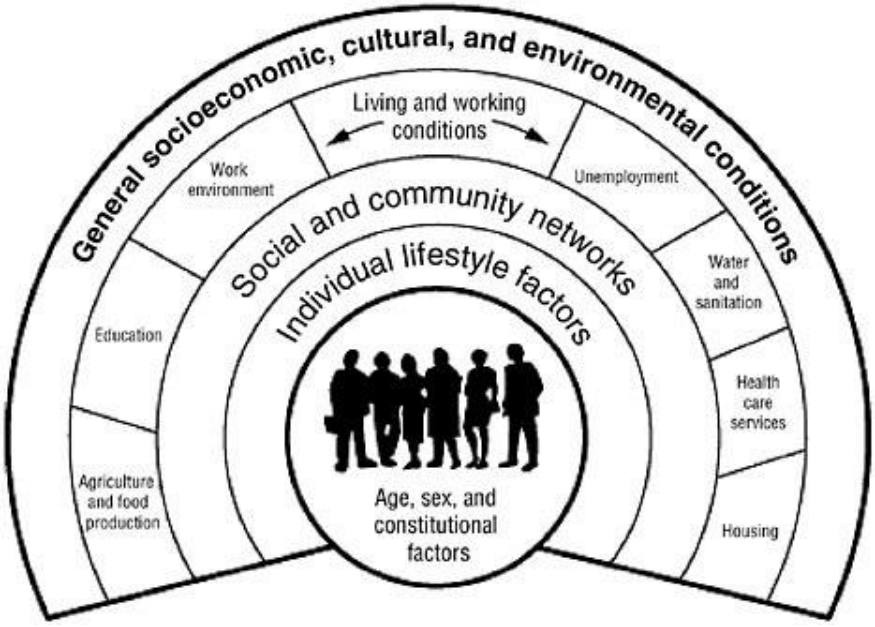
The research examines the neo-liberal market, the weakening of the state, together with a combination of decentralisation and privatisation that identified citizens as consumers and encouraged them to express preferences through market choices with the coproduction of services at a local level. The chapter acknowledges that central government whilst modernising the welfare state, through its policies on neighbourhood renewal and social exclusion, attempted to engage individuals and communities as partners, to build quasi-contractual arrangements between state and citizens, built on responsibilities and obligations (Newman, 2001: 144-146). The introduction of health policy that encourages involvement could be used to deflect attention from structural issues and shift the focus of responsibility for health to the individual. Gaventa (2006a) refers to citizens as having little ability to exercise real democratic power, and he places the emphasis on the institutions and the procedures where democracy is measured through competitive, multi-party, electoral processes that result in passive citizens. He suggests a third, liberal, representative view is defined and grows out of participatory democracy and this is where citizens exercise deeper control over the decisions which affect their lives (Gaventa, 2006a: 11). The chapter concludes by recording the strategic centralist and operational local changes that the front-line workers and local people experienced as they became involved in delivering the NDC health policy agenda.

3.2: Inequalities - The Health Divide

By 1995, prior to the introduction of the Third Way New Labour policies, differentials in the mortality rate in Britain, amongst all age groups had been substantively identified as two to three times higher amongst disadvantaged social groups than their more affluent counterparts (Fox, 1995: 10).

By 1991, Dahlgren and Whitehead's model (Figure 3.1) identified the main influences on an individual's health which categorised biological factors; the physical and social environment, personal lifestyle and health services. These had been acknowledged, when considering policy options, as a useful way of thinking in terms of considering layers of influence (Acheson et al., 1995: 22). Distinct areas of policy which influence health inequalities had been identified prior to New Labour's regeneration policies being introduced (Acheson et al., 1995: 23).

Figure 3.1: The Determinants of Health.



Source: (Dahlgren & Whitehead, 1991)

Whitehead suggested that the medical and health literature's evaluation of public health interventions to tackle inequalities in health had revealed four main policy issues that were important to address:

- Strengthening individuals;
- Strengthening communities;
- Improving access to essential facilities and services; and
- Encouraging macroeconomic and cultural change.

The fourth and final policy level, encouraging macroeconomic and cultural changes to reduce poverty in order to influence the wider adverse effects of inequality in society,

required building up self-confidence and skills in people and going beyond community development, which had traditionally been concerned with strengthening the way social dynamics work in the community. In order to achieve sustainable and long-term improvements, Whitehead acknowledged that three aspects – physical environment, economic opportunities and social conditions in the neighbourhood – were all interrelated and, therefore, a coordinated approach was essential (Whitehead, 1995: 32-36). Macro-economic and social policies span different sectors, and cross-national comparisons of health trends in OECD countries had shown a strong correlation between a more equitable income distribution and improvements in overall life expectancy (Wilkinson, 1996).

The emergence of the new goal of targeting health inequalities in geographical area-based populations was not one that government had previously identified as key. In 1977, the Secretary of State for Social Security Services for the then Labour government, David Ennals (1976-1979), had appointed a research working group under the chairmanship of Sir Douglas Black to review health patterns (Black, 1980). The Black Report documented the growth in private health provision, stimulated by the financial cutbacks on public service provision, and highlighted the huge disparities in local service provision and the resultant health inequalities this change had created, in particular relating to poor access to services by the socio-economically disadvantaged (Townsend & Davidson, 1982: 224-225). By the late 1980s, the Black Review, by highlighting that the death rate for a male in social class V was double that for a male in social class I, had brought into the public consciousness the fact that the gap between these two social classes was increasing, not decreasing, as had been anticipated. Whitehead introduced the term '*the health divide*' for this inequality (Whitehead, 1988: 221). The Black research working group had clearly identified the relationships between unemployment, health, housing, social polarisation and lifestyle as they affected a lower socio-economic demographic. The evidence on causes of how health inequalities were generated and maintained was explored by the working group under four main headings: artefacts, health selection, cultural/behavioural and materialistic/structuralist explanations. Material and structural factors were judged to be the main contributors to inequalities (Whitehead, 1988: 286). Prior to 1988, there had been few studies in the UK on the direct effect of income on health, partially because of the enormous, methodological difficulties encountered and partially

because of the political sensitivities. By 1986, the World Health Organisation regional office for Europe had set 38 targets to achieve 'Health for All by the Year 2000' acknowledging the importance of health policy and recognising that health care went far beyond health services (WHO, 2008: 2-5). The very first of these targets was improving the level of health of disadvantaged groups to achieve equity in health. The undertaking to reduce this health divide identified the radical steps that governments needed to take, which included large-scale experiments, introducing anti-poverty policies and giving priority to healthier lifestyles, with a focus on the poorest groups in particular (Whitehead, 1988: 219). The Black Review working group, comparing 1951 with 1971, identified a differential between occupational incomes and mortality. Those who experienced an income increase, relative to average earnings, were found to experience a relative decrease in mortality rates (Whitehead, 1988: 299). When the Black Review committee reported in 1980 to the incoming new Conservative administration they offered two main policy recommendations:

- *A total and not merely a service-orientated approach to the problem of health*
- *A radical overhaul of the balance of activities and proportionate distribution of resources within the health and associated services* (Townsend & Davidson, 1982: 198-208).

These recommendations suggested that attention needed to be paid to a total, whole-system approach to improving population health and they were acknowledged as '*ground breaking'* some 20 years later (Acheson, 1998: v-vi). However, the then current Secretary of State, Patrick Jenkins (1979-1981), within Margaret Thatcher's incoming Conservative government, apparently refused to endorse the working group's recommendations related to tackling inequality because of the additional expenditure required (Acheson et al., 1995). The Black committee had also documented the impact on housing and health and social care services caused by the emergence of the pockets of deprivation in geographical areas where communities were experiencing high unemployment with limited resources. The Conservative government strategy was to respond with individualistic health promotion models based on a whole-system approach (Platt, 1999) which included the introduction of targeted, area-based grants and single regeneration programmes. Co-incidentally, in 1979, the same year that poor health linked to geographical areas had been

documented and started to become apparent, the new, incoming Conservative government began their first term of office with a consultative paper that introduced an emphasis on the need for more decisions to be taken locally (DHSS, 1979).

3.3: Definitions of Health

Health inequalities hold major implications for the organisation of society, distribution of resources and the delivery of welfare services. This section introduces different classifications of how health is defined, and how these have evolved. With the plethora of solutions emerging from central government, all targeted at supporting a population's health and well-being, it predicates the importance of having a common understanding of what is meant by '*health*'.

Definitions of health include:

- The popular biomedical model evolved based on modern medical practices which focused on disease prevention or disease elimination at an individual level. A criticism of the biomedical model is that it is reductionist, concentrates on disease and does not acknowledge the wider, collective, social circumstances in which poor health thrives (Wade & Halligan, 2004: 329-330).

- Social health is thought to be comprised of three main features; independence and autonomy, interpersonal relationships and social maturity. The social economic model is a significant shift away from the previous biomedical model by which health had predominantly been defined, focusing on the importance of the impact of society and collectives, rather than disease (Acheson, 1998: 5-8).

- Aspects of mental health are thought to have both cognitive and affective dimensions that influence how individuals fulfil their potential or experience emotions (Tones & Green, 2004).

Engel (1977) acknowledged that, to effectively address health and well-being concurrently, medical practitioners needed to be concerned with all aspects of physical, social and mental health, and to know where and how to engage and empower and share power with individuals. The deprivation and disadvantages that needed to be addressed remained defined in general terms, for example;

'*a state of observable and demonstrable disadvantage related to the local community and the wider society or nation to which an individual, family or group belong'* (Townsend & Davidson, 1987: 125).

The comprehensive approach adopted by the World Health Organisation at the end of the Second World War with health as a '*state of complete physical, mental and social well-being and not merely an absence of disease or infirmity*' (Townsend & Davidson, 1982: 33) is usually called the '*social*' model and worked both within and outside of medicine (Townsend & Davidson, 1982: 320-33). By 1997 when the NDC policy was introduced, this social model had been widely adopted.

By 1998, the Acheson Report had highlighted the need for strategic central and local action, as many the of determinants of health inequalities lie outside of the actual health care system. It suggested that, to work effectively across organisational boundaries, partnership with local authorities, voluntary groups and the business sector was needed and local people needed to be involved in developing and providing services (Acheson, 1998: 118). An assessment in the mid-1970s had identified that Britain was falling behind other countries in health improvement, despite thirty years of the welfare state (Acheson, 1998: 4). Internationally, the World Health Organisation had previously identified that physical health necessitated reducing the effects of disease and disability whilst also increasing an individual's well-being and levels of personal fitness (WHO, 1948, no. 2: 100).

The accepted definitions of health and well-being influenced the development and the establishment of the targets within the NDC regeneration programme, which identified six themed areas that needed monitoring over the ten years of the programme (NDC 2001: 28-41). Health was now acknowledged as a complex state which included aspects of an absence of disease, mental health and social well-being. The introduction of the six cross-cutting, target areas, which the NDC used to establish its programmes to begin to improve health (ODPM, 2001) was the first time that complex, multi-causal factors affecting health had been worked on within a regeneration programme, placing wider responsibility for good health with not just the clinical or medical practitioners, but also within the community. By 2009, Stafford et al. (2008) when evaluating the tackling of inequalities in health in the NDC initiatives had summarised that area based programmes were thought to be popular amongst

policymakers because they were: *(1) assumed to be an efficient means of targeting the most deprived individuals; (2), provided the context for involving local people in identifying local problems and delivering solutions; and (3) it was a recognised that there was a need for robust evidence related to the impact of area-based initiatives on health and health inequalities.* (Stafford et al., 2008: 298).

3.4: Working together involving all partners

The thesis discussed in Chapter 2 how the health and social care structures in the 1960s began identifying the need to work in partnership with civic society. Back in the 1920s, prior to the formation of the NHS, an influential social experiment in East London - the Peckham Health Project – explored concepts and factors affecting health and well-being. It examined the wider determinants impacting on community health, and partnered with local people to improve the impact of medicine on well-being and increase the absence of disease within a defined local community. When the original Peckham Health Project closed in 1950, it had been a pioneering example of a geographical area-based initiative seeking to establish partnership solutions, working with patients to actively promote health rather than only treating disease (Conford, 2016). The Peckham Health project was critically acknowledged as an ambitious experiment that, rather than simply using medicine to cure disease, tried to reconceptualise the role of clinical medicine by integrating its practice into the life of the community and shifted the focus towards health promotion by various means (Engel, 1977: 129-136*).* As part of the research thesis, a group of the NDC respondents undertook a number of field trips to explore and learn about the divergent models of health service delivery. The Bromley by Bow Centre is an innovative charity operating in East London (Castillo et al., 2016: 22) and modelled its health and well-being services on the 1950s Peckham Health Project. Over the last 20 years the centre has worked to transform people's lives in some of the most deprived neighbourhoods by focusing on unlocking talents and skills, founding businesses, employing local people and providing goods and services to the community. It believes that people have capacity to achieve amazing things, and hosted the NDC local community and front-line workers in 2001 when Health Focus Group (HFG) and Community Health Action Plan (CHAP) members went on a field trip to visit the project. A key issue central to this research study was the relationship between the actors involved in working within the NDC health design. The Bromley by Bow centre involved all the citizens

using the health centre, including the professionals, the planners and the community volunteers, all working in partnership. A key underlying principle carried forward from the Peckham Health project, which was demonstrated in the Bromley by Bow Centre, was an acknowledgement of the multifactorial influences which affect health. This topic is explored further in Chapters 6, 7 and 8. This field trip helped shape the line-workers and local people who were developing the NDC Health Focus Group Plans and encouraged them to incorporate a strong clinical, complementary and voluntary aspect into the design of their new NDC health service (NDC delivery plan, 2001: 60).

By 1997, the centrality of the concepts of involvement and participation within the emerging service user groups had become of major interest. There was a growing new emphasis on '*public participation* 'and community involvement to achieve public health goals, and the recognition that the people who are at the receiving end of the delivery of public health or health care interventions needed to be involved. (Beresford, 2016: 447-8). Deliberative processes and the best ways of disseminating information and public health planning to ensure that the community's voice is present in the decision-making was a growing focus within the public health sector (Scutchfield et al., 2006: 76-77).The local strategy for action to address health inequalities in the city where this research project was located identified that by 2020, members of the community will be actively engaged in decision-making, delivery, evaluation and scrutiny; enabled and empowered to be responsible for their own health and confident in the health system (Higgins et al., 2004: 13). Public health specialists had identified the key targets for engagement with either individual members of the general public, or specific, local communities' ethical groups, health service users, or potential health service users, carers, self-help groups, consumers and organisations that represent the interests of the health service (Pencheon, 2001: 482-490).

Models such as Arnstein's *'ladder of participation'* had been developed as a theoretical framework to measure differing levels of community participation (Arnstein, 1969). A cross-national comparison study of civil society and community involving five countries conducted by Almond and Verba (1963) identified Britain as having the most pronounced civic culture. Three decades later, when the NDC regeneration policy was introduced, Arnstein's '*ladder of participation'* (Arnstein, 1969) was still widely used in the public health arena as the model for strategic health planners and community

health development workers.

Ledwith identifies participatory practice as involving structures that enable participation in helping develop critical connections with others in ever widening networks. She suggests that much of the existing participatory practice that involves service-user or consumer-choice language is narrow and towards the tokenistic end of Arnstein's '*ladder of participation'*, particularly that used by management and bureaucrats (Ledwith et al., 2010: 92-93). Ledwith underlines the importance of health service providers measuring the impact of their approaches, to provide evidence and measure, within public health practice, the extent of citizen participation in the implementation of health initiatives. Fung et al., (2001) argued that facilitating active involvement of citizens and forging political consensus through dialogue, and devising and implementing public policies that enable a productive economy and healthy society is a more radical egalitarian version of the democratic ideal of ensuring all citizens benefit from the nation's wealth (Fung, 2001: 5-41). The implementation of the NDC policy directly involved the development and support of participatory initiatives, and Chapters 6, 7 and 8 analyse the involvement, mapping and deliberative democracy of the key respondents throughout the research period.

The NDC programme sought to focus on the wider determinants impacting on health, and the influences that shape an individual's control of their health. However, civil society's involvement and influence on health services' provision was not evident in the NHS as Thatcherism introduced neo-liberalism, promoting free-market policies, economic individualism and acceptance of inequalities (Ledwith et al., 2010: 41). Government instituted its health policy from the centre, while devolving power to NHS and local authority structures to implement locally. The previous paternalistic culture of the medical profession led to these local health and well-being structures being controlled by technical experts (Rose, 1993: 122-129). The requirement to start enabling people to successfully implement local health choices introduced a complex new dynamic which impacted on politicians, health professionals and citizens and created the need for new mechanisms for power-sharing (Davies et al., 2013: 172-176),

3.5: The history of the Welfare State pre-1997

The social changes after World War II and an emerging notion of the welfare state led to the Labour government, in July 1948, creating the National Health Service (NHS). The then health secretary, Aneurin Bevan, introduced the utopian aspirations of a national health service (NHS) that was universal, equitable, comprehensive, high-quality, centrally funded, and free at the point of delivery, offering health services that would be available to all and financed from taxation (Delamothe, 2008: 1490). The NHS was introduced to support a universal public provision of welfare services which were administered managerially and financially through state planning. It had a centralised 'command and control' style of management that continued within the NHS under successive governments until 1979 (Townsend & Davidson, 1982: 24; Greener, 2006).

In 2000, the Office of Health Economics identified that private health insurance funding of health provision had doubled within the previous two decades. However, while this number had doubled, it still only represented less than 12%, or 7 million individuals out of a possible 60 million, a relatively small proportion of society. Although from 1979-1988 the Conservatives had championed the radical goal of privatisation of the NHS, the central government still found it politically expedient to fund public healthcare from general taxation (Greener, 2006: 504-506).

NHS health resources were largely financed from the system of national, social insurance and the professionals delivering within the welfare system were seen as key partners in the delivery of the processes throughout the 1960s/70s (Stoker, 2004: 154-74). By the 1980s, a plethora of new models, including businesses and markets had been introduced (Gorsky, 2008: 751-771). Active, participatory involvement of local communities in the '*community health movement*' increased, with more citizens involved in the transformation of services and local populations partnering in promoting their own health. Tensions between professionals and lay people were identified (Ledwith et al., 2010: 35-58; Popay, 1996: 6-14). Popay's investigations identified challenges to the authority of health professionals in determining which way the problems are defined in the policy arena. She suggested the realm of '*population health represented both an epistemological challenge and a political challenge to the institutional power of expert theories*' (Popay, 2006: 571).

With the introduction of an internal market for health care, Clarke suggested that the local democratic agenda had been shaped to the right-wing ideology of a consumer-orientated market, resulting in the concept of the '*consumer state*' (Clarke, 2004). Consumer feedback strategies, such as consumer satisfaction surveys and other customer style mechanisms, became the benchmark measures of the 1980s. Development corporations were introduced to stimulate market mechanisms and encourage local economic growth. Private sector powers increased as local government powers diminished (Stoker, 2004: 117-119). The Griffiths Review (1983) continued to identify patients as '*customers*', which, together with the introduction of the new internal market, and new, coherent, local management structures was heralded as a major decentralisation of healthcare (Stoker, 2004). Wanless suggested the amount of funding needed for future health services was likely to be affected by the underlying health of the population; identifying that increasing levels of lifestyle-related disease and the growing elderly population would put increased pressures on health budgets (Wanless, 2002).

3.6: Deindustrialisation and populations experiencing health inequality

After the introduction of these consumer and internal market policies, the inner cities experienced deindustrialisation and decline due to a shift in the location and nature of industry and local employment (Alcock et al., 2012: 455-456). A demonstrable decline of the health status of the populations in the inner cities from 1980 – 1990 was identified (DETR, 1999: 113-129). The evident rise in social deprivation suggested that services in these urban areas were underperforming, particularly in terms of health and social care delivery (Wilkinson, 1996). Problems of urbanisation in the inner cities increased inequalities and reduced access to jobs, housing and education, resulting in a decline in people's well-being. Additionally, health management in the urban environment also identified larger populations living in the inner city areas experiencing poor quality of life, with a greater incidence of living with long-term, limiting illnesses (Acheson, 1998: 103). Within these urban areas, there was little or no potential for any imminent, local, economic growth, and the population's health was deteriorating and poverty was increasing in specific localised areas. At the same time, local government was experiencing a failing of democracy, with diminishing powers and low electoral turnouts, and the polarisation of rich and poor increased (Pratchett, 1999).

The managing director of Sainsbury's, Roy Griffiths, together with three others was invited to undertake a review of the NHS (Griffiths, 1983). The review concentrated on management within hospital services, highlighting that both community health services and family practitioner services behaved as separate services. What was proposed was a fundamental restructuring of NHS organisations, reorganisation of duties, responsibilities and accountability. However, what Davidmann (1984) suggested was completely missing from the enquiry was grassroots representation from all those who would be affected by the enquiry's findings, namely, front-line workers, nurses, doctors, technicians, ancillary staff, NHS patients and the community at large including the Community Health Council or the Trade Unions (Davidmann, 1984: 4-6). The Griffiths' analysis identified that, from a business point of view, there was a clear lack of well-defined, general management function throughout the NHS. This suggested a need to assign to specific people at different levels of the organisation, the responsibility for planning, implementation, control and performance. The Griffiths' review also suggested that the absence of general management meant that there was no driving force accepting personal responsibility for developing management plans, securing the implementation of programmes or the monitoring of actual achievements. It proposed that the NHS required major changes in the management process from the central parliamentary level down throughout the NHS management system. It recommended, in order to develop a coherent management process, the DHSS should be rigorously pruned of many of its existing activities. NHS management costs were to be controlled by establishing management mechanisms such as the Regional Health Authority, identifying targets, developing National Performance Indicators and improving efficiencies (Gorsky, 2008: 89). Griffiths suggested that a budget system needed to be established based on budgetary management models that operated within the context of a total management process and that resources should be left more to local management (Griffiths et al., 1983: 10-14). These management reorganisations, introduced as mechanisms to improve efficiency, together with the introduction of consumerism through the Community Health Councils (CHCs), contributing to the marketisation of health services, were introduced by the Conservatives after the 1983 Griffiths' report. The DHSS directive to all Health Authorities stipulated that all ancillary services (which represented 12% of the total NHS expenditures) were to be put up for competitive tendering (DHSS, 1987).

By the 1990s, there had been a shift within the NHS from the 1970s' hierarchical and bureaucratic style of organisation into a more commercial market style (Exworthy, 1993). Noticeable throughout this transition period was the retention of a degree of centralised control within policy-making and resource allocation, which continued to limit the neighbourhood decisions taken by local citizens or front-line workers (Gorsky, 2008: 751-756).

3.7: Purchaser provider - Health service delivery

During the second half of the term of the 1981-1997 Conservative government, they introduced further market mechanisms with a greater distinction and split within the NHS between the providers of health services and the commissioners of health services (Klein, 1995). This clear delineation between the commissioners as '*purchasers*' and the health service as '*providers*' introduced additional competition. It also compounded further the fragmentation of health provision, destabilising the coherent provision of services and restricted joint working and partnerships. The Conservative government suggested that these changes would produce a more entrepreneurial NHS. This focus on the market was also reflected with the introduction of compulsory competitive tendering and, notably, the emergence of public-private partnerships and private finance initiatives (Terry, 1996). The private finance initiative (PFI) was established in 1992 by Norman Lamont, as Chancellor of the Exchequer, to privatise specific construction projects. It was greatly expanded under the Third Way by New Labour with the total debt incurred through PFI projects rising tenfold, to £200 billion of public debt. The biggest user of PFI was the NHS (Centre for Policy Studies, 2012: 6). This is discussed further in Chapter 4. The impact of the introduction of the PFIs, as understood by the respondents, is included in Chapters 7, 8 and 9.

Under the Conservative government, the NHS had moved towards a contract model, based on the American style of competition, replacing the previous Soviet-style '*command and control'* model (Greener, 2006: 504-506). The NHS continued to profess that it was a publicly funded system, even with the introduction of private funded healthcare. Whilst conservative politicians had sought to stimulate the internal market and private investment, the low take-up of private insurance meant it was found expedient to maintain the idea of public-funded healthcare on sound fiscal grounds. The Treasury continued to manage health funding centrally which ensured

government continued to exercise a considerable amount of control over state finance of local initiatives (Stoker, 2004).

3.8: NHS and Local Authorities in 1997 under New Labour

The internal market created by the NHS restructuring and the Community Care Acts meant that by the 1990s health authorities were managerially responsible for the finances and commissioning across a range of providers. In 1991, 57 NHS trusts were established, with the stated intent of making health services more responsive to users at a local level. The introduction of NHS Trusts was intended to encourage creativity and innovation, and to challenge hospitals to deliver more services within the community. These NHS Trusts were independent organisations that had their own management structures whilst, simultaneously, the newly introduced Regional Health Authorities adopted a different, lighter management touch. These changes were combined with patient partnership programmes, in which citizen-based panels and juries experimented with representative democracy, and an increased use of participatory deliberative mechanisms with the '*voices'* of the public and especially '*the poor'* being increasingly sought (Cornwall & Schattan Coelho, 2007: 4-5). The changes were intended to generate a stronger feeling of local ownership and to support increased social cohesion within communities (Greener, 2006; Gorsky, 2008).

The new health policies introduced by the Labour government in 1997 further decentralised the provision of health services with the reorganisation of the Community Trusts into Primary Care Trusts, the introduction of Health Authority Trusts, and the establishment of Regional Health Authorities. These new frameworks were ostensibly introduced to decentralise health services and concentrate health provision within smaller neighbourhoods, in order to have a greater impact on local networks (Alcock et al., 2012: 332-334). Peckham proposed that these changes were simply organisational restructurings and did not lead to increased public participation through local networks (Peckham, 2005). These changes within community health and the new, general-practitioner frameworks occurred at the same time as the introduction of new finance and management structures controlled by the centre. Skidmore's (2006: 5) research explores the new participatory opportunities that the regeneration policies introduced post-1997 for community participation across a range of service providers (Table 3.1).

Table 3.1: Opportunities for community participation in governance Post-1997

Sector	Opportunities for community participation in governance
Education	Sure Start: school governing bodies: parent governor representation on education scrutiny committees
Health	Foundation Hospitals; Primary Care Trusts; Public and Patient Involvement Forums
Housing	Arm's Length Management Organisations; Tenant Management Organisations; Home Zone Challenge
Regeneration	Local Strategic Partnerships; Community Empowerment Networks, Community Chest, Community Learning Chest; New Deal for Communities Board; SRB regeneration boards
Local Government	Neighbourhood Management Pathfinders; Civic Pioneers; Local Area Agreements
Community Safety	Youth Offending Panel; Police Consultative Panels
Planning	Statements of Community Involvement; Parish Plans; Village Design Plans; Town Design Plans

Source: Adapted from: (Putting the Public Back into Public Policy) (Skidmore et al., 2006: 5)

3.9: Overview of the Welfare State and its evolution

By the mid-1990s, state facilitated health service delivery was acknowledged as being under increasing financial pressure and the need for the system to be redesigned was widely recognised (Wanless, 2002). By 2010, as Jordon pointed out in his analysis and critique of the Third Way, because of the increased managerial complexities of these new state systems, the demand for NHS monitoring and meeting targets, such as reduced waiting times, monitoring had taken precedence over interagency collaboration. He suggested that the Third Way was based almost exclusively on contractual regulation, substituting systems aimed at fulfilling abstract rules and meeting economic values versus meeting specific, interpersonal, negotiating standards, that create '*social value*' (Jordan, 2010: 4). This is explored further in Chapter 4.

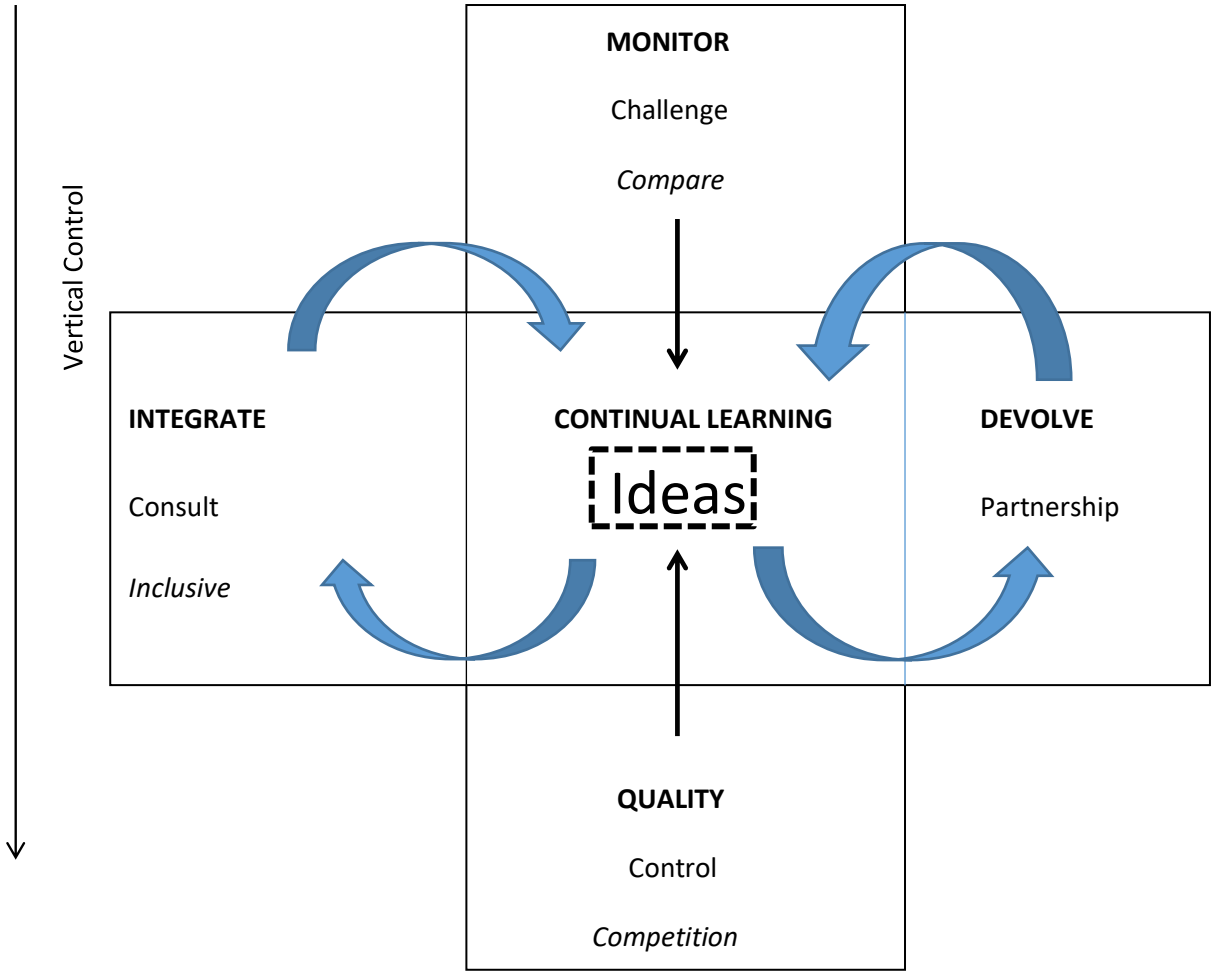
3.10: Participatory Democracy - Civil Society – Regeneration

By the late 1990s, the UK's public health policy had acknowledged and adopted the principle that service users should be actively involved in the decision-making process (Cornwall & Schattan Coelho, 2007). The theory of '*participatory democracy*'

discussed by Ledwith (2010) explored a process of enhancement in representative forms of democracy. A partnership drive was part of the wider modernisation government agenda, moving away from a centralised, hierarchical model of government towards a more flexible responsive process of local government (MacKian et al., 2003: 224). The vision for the new public health had been shaped by a range of social, environmental and psychological influences and Mackian et al. (2003) identified a range of models which help to understand the complex public health policy and operational practice spaces. They refer to the NHS plan (Department of Health, 2000) recognising the outdated nature of the current health service, the need for flexibility, and the provision of services driven by a participatory set of 'consumers.' Incorporated in the new public health delivery and emergent '*political public spaces'* is a necessary social transformative process. Transformation is brought about by partnerships, where professionals and the various actors connect in complex, interconnected ways that enable them to be involved in decision-making. They suggest that, if greater participation with local agencies is to be more than palliative, it must involve shifts in power. The Development of Health Improvement Programmes (HImP) (Department of Health, 2001) held a central role, offering an opportunity for a discursive process involving joined-up working across national, regional and local partnerships. They identified the need for integrating the vertical controls and moving towards a more horizontal enabling framework for public health work (Figure 3.2).

As well as changes in the role of the individual service user, the New Labour public health policy environment also involved a redefinition of the roles and responsibilities of the state. Their policies moved from the 'command and control' of the previous government, and shifted to an emphasis on participation. New Labour's Third Way sought to redesign and deliver public services in the context of participation within the market and by involving a wider civil society. Differentiating between policy-making and governance within a public sphere suggested that the conditions were developing which could also allow building on community capacity and greater collective action (Barnes et al., 2007: 57-58; Boyle et al., 2002; Blair, 2001; Davies, 2009).

Figure 3.2: Vertical and Horizontal Governance



Source: Adapted from Mackian et al., 2003: 221

3.11: Workforce skills required to deliver the NDC

The introduction of the New Deal for Communities programme highlighted the growing importance of a skilled front-line workforce (Diamond & Liddle, 2005: 35-38). The change agenda for the workforce was critical, as, over the 10-year time span of the programme, front-line operational staff needed to be able to understand, create and negotiate the complex environment within the new, area-based initiatives. The Department of Health's centralist reforms were also changing the operational role of front-line workers (DOH, 2000; DOH, 2001.) Diamond & Liddle (2005) identified a potential skills deficit as the NDC regeneration policy changes were introduced. The workforce managing the new, area-based work needed to be able to undertake complex facilitator managerial roles, and also be able to work across operational, tactical and strategic levels. They highlighted that there was a limited workforce of skilled people with the right background who were able to work across the different cultures, because either people had been lost through retirement or had a skills deficit. New Labour's regeneration policies also involved utilising service users and volunteers, which, at the time of the introduction of the ten-year, area-based programme, was unprecedented. Similarly, the concept of joined-up working across a range of disciplines was a new concept in the management of regeneration programmes and needed a period of transformation and change to enable the regeneration managers to gain the specific understanding and skills they needed to work effectively (Diamond & Liddle, 2005: 25-31).

Little attention was paid as to how the new policies would be implemented and delivered. The implementation process was influenced by professionals and social actors. The actors implementing the changing policy environment had to learn to navigate the tensions between centralisation and decentralisation to support empowerment and devolved control. Delivery of the NDC necessitated building enhanced trust across all actors for the changes to be successful (Newman 2001: 99-101).

Costongs & Springett (1997) suggested that the success of the inter-agency partnerships in the neighbouring city of Liverpool had stemmed from first building trust and strengthening reciprocity between all of the actors involved, which highlights the importance of a skilled workforce. Pickin et al. (2002) also claimed that the need for

trust amongst the key, local actors emerging within the complex of different dynamic partnerships, while giving enough time for the growth of strong relationships within communities, was vital to building integrated working relationships. She suggested that models for increasing the capacity for participation in communities were more likely to succeed when a range of strategies based on increasing trust and community collaboration were incrementally implemented, thus securing a firm network and foundation for future work. Prior to the award of the grant, applicants to become a site to deliver the NDC programme had a year when local stakeholders worked together to submit a partnership proposal for approval by the Office of the Deputy Prime Minister (ODPM). The ODPM was established in 2001 and was facilitating and overseeing the work of the Department of Communities (NDC, 2001).

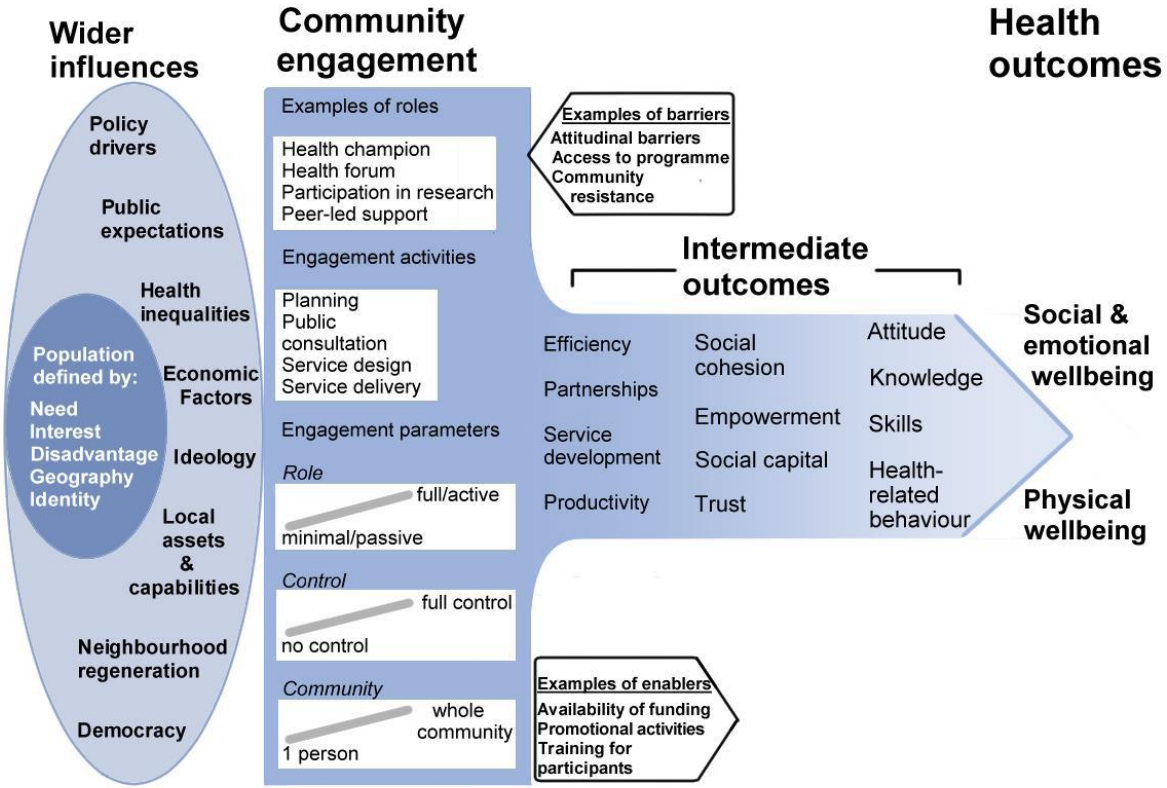
The National Institute for Health and Clinical Excellence (NICE) undertook a review of community engagement strategies used in the past and offered national guidelines to help the health sector maximise the impact of their community engagement inside area-based initiatives aimed at addressing the social determinants of health (NICE, 2008). This NICE review used meta-research analysis and contributed to the commissioning of formal evaluations of initiatives such as the HAZs, NDCs and the Sure Start schemes.

A Project Development Group (PDG) of the NICE Project Team highlighted four interlocking themes that were necessary prerequisites for success:

- *Policy development*
- *Approaches that support practices on the ground*
- *Approaches that support increased levels of community engagement, and*
- *Evaluation*

Even though their review drew on a wide range of both qualitative and quantitative research and looked at several study designs, their findings included the statement '*that further research and evaluation was needed to develop a systematic evidence-based approach to community engagement.*' (NICE, 2008) (see Figure 3.3 overleaf).

Figure 3.3: Logic model



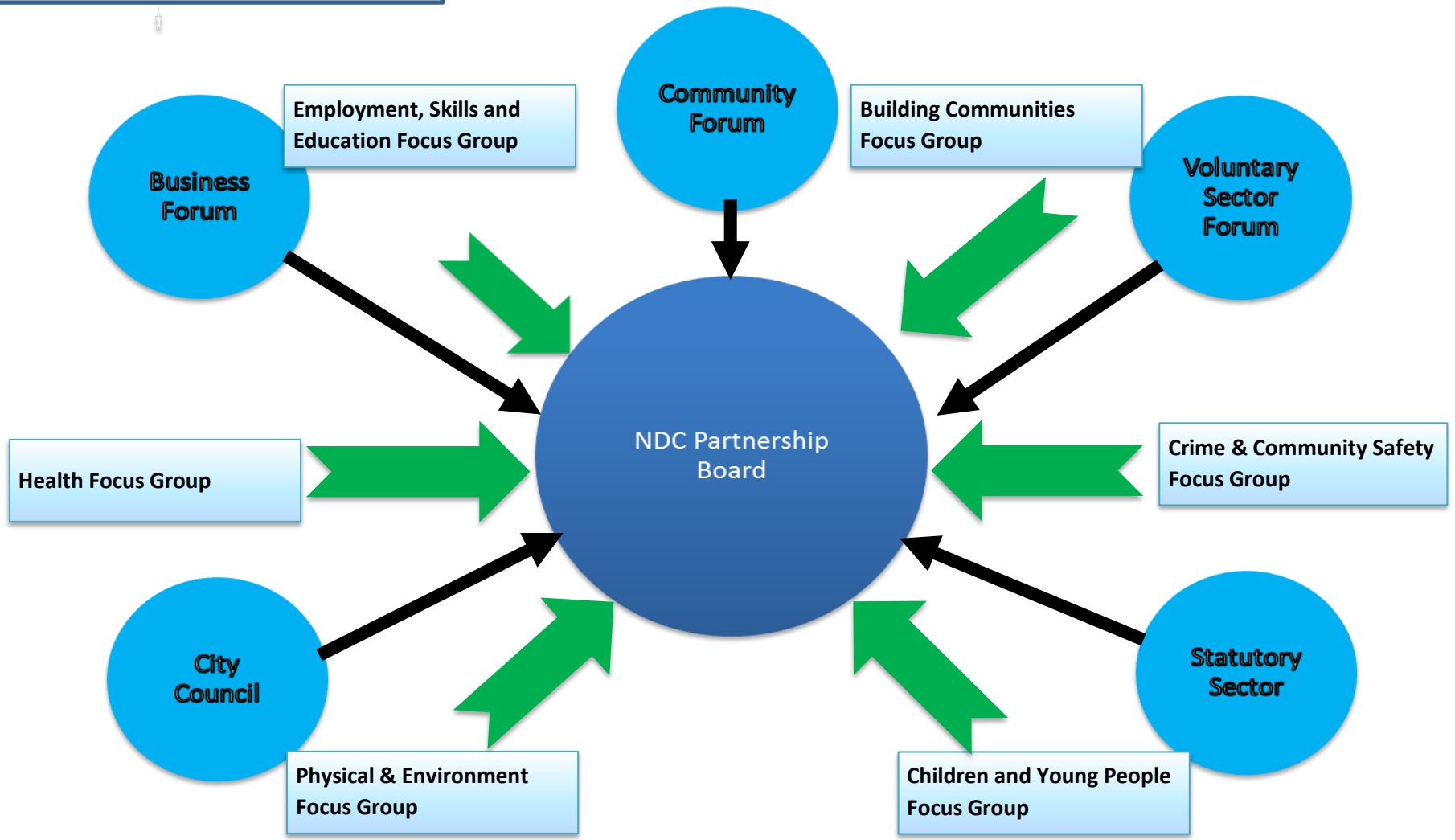
Source: Adapted from NICE community engagement scope (2014).

3.12: Conclusions

Chapter 3 has positioned the context of the thesis inside the complex, evolving health and welfare services that were being operationally restructured at the same time that New Labour introduced and implemented the NDC regeneration policy. Defining health and health gains and establishing the outcomes and agreed measurement tools were important aspects of the start-up and development of the NDC programme in 1997. Additionally, the start-up of the joint NDC Partnership Board and their six, themed, focus groups and enlisting their membership was critical to the success of the NDC programme (Figure 3.4 overleaf). The introduction of the NDC policy meant that previously untried participatory methods needed to be facilitated by workers to introduce local actors to the process. This was the complex environment in 1998 when this research on the New Deal for Communities was first introduced. Negotiating the complexities of the decision-making across the proliferation of networks introduced by the NDC programme challenged the local partnerships and the regeneration managers responsible for leadership within the regeneration initiatives (Diamond & Liddle, 2005: 194-196). This aspect is explored more in Chapter 4. As an inside researcher, my previous work experience was critical in obtaining a broader understanding of the complexity of the various cultures, and supported my efforts to determine how best to facilitate the involvement of all the local actors to maximise success. Power-sharing, understanding the various dynamics and knowing how interpersonal relationships can work to support community participation were critical. The successful introduction of the NDC policy would not only impact on an individual's health on a one-to-one basis, but also their ability to work effectively in collectives.

Working within the NDC health collective's focus groups necessitated facilitating communication, sharing power and maximising individual involvement whilst also promoting the wider impact that working as a collective would have on the group's goals. As Barnes et al. (2007) identified, it was not only inequalities that the new participatory governmental discourses highlighted, it also involved power. Managerial and professional actors with experience of community development or service-user involvement came to prominence. However, in moving from the margins to the mainstream of organisational hierarchies and when sometimes leading on importantly new partnership initiatives, these actors come into conflict with established power bases. She identified pressures and strains that might result from having to

Figure 3.4: NDC Governance Structure



face both inward to the strategic centre of an organisation and outward to service users or the community (Barnes et al., 2007: 195-196). Delivering on the NDC regeneration policy involved, at times, bridging the role of the institutional actors and dealing with tensions, conflicts and ambiguities. Opportunities within the existing health and social system condoned or supported involvement (Baum, 2000), however, the impact on individuals or collectives of health economics and the centralist, strategic, political activity were often less visible influences on the success of community participation.

The front-line workers and community respondents interviewed within this 10-year, longitudinal, research study explored their lived experience of the challenges created by these organisational, policy and fiscal changes. The study captured, as they experienced these changes, the individual respondents' inside voices as people living and working in the area-based NDC initiative, in an area which, at the outset of the initiative, was identified as and defined by having social, economic and access disadvantages.

4: Centralist Political Regeneration Ideology

4.1: Introduction

The research explores participatory governance, citizen involvement and the new spaces that the New Labour's policies introduced to increase local system governance. In this chapter, the multiple policies emanating from different government departments within the first two terms that New Labour was in office are introduced and aspects that refer to community involvement, active citizenship, social entrepreneurs or joint partnerships with local actors are highlighted. This chapter provides an overview of the previous changes in health, welfare and regeneration policies and the confusion introduced by the New Labour policies. In particular, the process of the implementation of the neighbourhood renewal (NR) policies that the New Labour government introduced in 1997 is explored, and the systemic and structural impact of these policies on citizen participation in the delivery of a New Deal for Communities (NDC) area-based programme. Chapter 4 documents the health and social care restructuring at a local level, which was claimed as being necessary to address inequality and poverty inherited from the previous government. The chapter introduces constructs of '*joined up governance*' which emerged as a key policy discourse in the modernisation of local health and social-care delivery, together with the rational for an integrated approach to working across welfare systems locally within neighbourhoods. An overview is provided and introduce the increased emphasis on individualism, bottom-up participation and the growing self-help movement, with the greater focus on choice, individual responsibility and consumerism within the Third Way policies is introduced. The impact of the policy changes on the involvement of local actors and corporate partners in localities and the emerging multi-layered governance within regeneration and public health models is provided. Chapter 4 also links the impact of the central government fiscal and regeneration policies introduced into the NDC areas by the Labour government.

This Chapter questions whether the introduction of the NDC regeneration policy became part of a top-down imposition as a centralist government response to increasing global financial pressures and a rational response to the political, social and economic situation that allowed public institutions to adjust to the new economic environment. It questions whether the focus on greater choice and individual

responsibility was a continuation of the previous Conservative government's neo-liberal policy attempts to introduce a competitive market economy and a means of deflecting attention from addressing the changes needed in the structural determinants to address health inequality and poverty.

4.2: Prior to 1997

Prior to 1997, the central government had introduced an urban regeneration policy which sought to address the issues of coordination and co-governance. Diamond suggested that, by the mid-1980s, the need to understand and analyse the important aspects of its delivery such as the interconnected relationship between economic development, public policy-making and service delivery was critical. In the UK, an absence of this reflective analysis had resulted in the development of local regeneration initiatives which he suggested had little chance of success, particularly within the context of policies that were introduced to enhance local democracy and citizen engagement (Diamond & Liddle, 2005: 19-21).

In setting out the context of the research framework - the new public spaces, emerging markets, changing networks and citizen governance - Newman (2005a) suggested policies and strategies are likely to cut across the organisations, individuals and collectives in complex ways. She argues that the constituency and boundaries of the emerging public spaces in which participation is enacted are both fluid and contested. She quotes Habermas's work with governance theorists and notes the emergence of multi-layered governance, and that the dispersal of power to multiple collectives and agencies within the different sectors is likely to challenge the importance of representative organisations. (Newman, 2005a: 82-121). The implementation of the bottom-up participation within NDC health policy programmes necessitated a wider understanding of the significant local and central relationships, and critical reflection with an appreciation of the contribution of both theory and the dominant ideologies located in the social and political regeneration context (Ledwith, 1997: 95). Citizen involvement and empowerment, together with communities' experiences of the impacts of increasing poverty and inequality and their relationships with the emerging self-help movements, was highlighted by Beresford as discussions mainly led by politicians, discussions which needed to include the voice of people who had direct experience themselves and were involved in the day-to-day struggles (Beresford,

1993: 4 – 19: Beresford, 1999: 3).

4.2.1: Reformulation of Labour

Following three successive electoral defeats, Blair had persuaded the Labour party to change Clause 4 of Labour's constitution from 'equitable distribution and common ownership', and had shifted the party's thinking towards an alternative to the Conservative's market individualism (www.socialistparty.org.uk/articles/3792). As Richards (2000) discussed the emerging New Labours participation politics in the Fabian society publication the Labour Party membership adopted the revised Clause 4 which states '*To these ends we will work for a) a dynamic economy, serving the public interest, in which the enterprise of the market and the rigor of competition joined with the forces of partnership cooperate to produce the wealth the nation needs, and the opportunity for all to work and prosper within a thriving private sector and high quality public services where those undertakings essential to the common good are either owned by the public or accountable to them* (Labour Party Rule Book, 1995, Clause 4a). This new approach also rejected the collectivist, centralist and socialist approach of Old Labour (Giddens, 1998: 8-11). Giddens suggests that the implementation of this New Labour Third Way ideology was intended to introduce and provide new material conditions and organisational frameworks in defence of the policies in the public domain, during a time of increasing globalisation and financial uncertainty. The new policies introduced during Labour's first term of office were promulgated as enhancing '*spreading the opportunity and intended to encourage greater coordination, strengthen community capacity and increase the political decisions taken by individuals and groups*' (Giddens, 1998: 12-14; Blair, 1998: 5). Giddens also suggested that the state, particularly the welfare state, was destructive of civil order, while markets were not, because the markets thrive on individual initiative. Markets are discussed in more detail in Chapter 2.

In 1996, Blair suggested '*I believe in greater equality. If the next Labour government has not raised the living standards of the poorest by the end of its time in office it will have failed'* (Blair, Independent on Sunday, 28.7.96: 1).

The introduction of New Labour's Third Way '*policy entrepreneurs*' from such think-tanks as the Institute for Public Policy Research (IPPR), Demos and Nexus were to inform and support Blair's political ideology (Lavallette, 1999) While under John

Smith's leadership, the Labour party had acknowledged a commitment to the reformulation of welfare policies and a need to tackle inequality and poverty by redistribution. Under Blair and the new Third Way ideology, the party emphasised the need for welfare reforms combined with greater responsibility for individuals. New Labour claimed welfare developments needed to be joined with communitarian ethics and guaranteed citizen rights in return for responsibilities to the nation. They also saw a need to modernise British institutions to become dynamic, enterprise-based economies.

4.3: Post 1997

When New Labour came into power, the deprivation at the local authority ward level had deepened, notably in the economic domain, and coordinated delivery and co-governance had been unsuccessful in sustaining change (Mallinson et al., 2003: 771-773; Savage, 2015: 392–399). New Labour's Social Exclusion Unit (SEU) (1997) identified the necessity of bringing together the multiple factors that impacted on deprivation to tackle the causes of social exclusion, and the need to develop a coordinated, integrated, sustainable approach to implementing regeneration policy (SEU, 2001: 7-11). '*Building Britain Together'* identified the causes of deprivation as emerging from multiple factors (Social Exclusion Unit, 1998: 58-59). Claiming that problems had been compounded by a lack of comprehensive, short-term, new policies, and a lack of coordination between different central government departments or between central and local government and the neighbourhood level (Social Exclusion Unit, 1998: 6-11), the strategy presented in '*Bringing Britain Together*' identified three strands:

- A range of national programmes intended to tackle social exclusion i.e. the New Deal for jobseekers;
- New funding programmes designed to regenerate poor neighbourhoods e.g. a New Deal for Communities focusing on comprehensive activity and small neighbourhood areas; and
- Detailed comprehensive information, with cross-cutting, policy-action teams, in order to develop a long-term strategy.

The previous lack of comprehensive, long-term, regeneration policies to tackle the disparity between local authority wards was identified by the SEU and the focus

became the '*community*' as the primary means of driving the neighbourhood renewal agenda (Diamond & Liddle, 2005: 78). Within New Labour's wider neighbourhood renewal (NR) strategy, ways of working in partnership were introduced with detailing how the policy should be managed. It acknowledged processes such as boundaries, decision-making, and who should participate, and it was also concerned with coordination and co-governance. As an experiment in policy-making, Blair suggested that neighbourhood renewal and the SEU was vital to the country's future and identified three collective goals for the SEU: 1) to bring about joint working at the neighbourhood and local level 2) to make it easier for communities to influence decisions 3) and to bring national government to the table as an active partner (Blair, 1997). Hilary Armstrong MP (1997 – 2001) was a key player in the introduction of these new health policies that Labour had designed before taking office. Armstrong spent the first four years of New Labour's term of office as the Minister for Local Government Regions with responsibility for local government (LG). It was under her guidance that a range of policy initiatives were introduced, together with the development of the Local Strategic Partnerships as one of the Action Teams central recommendations.

New Labour introduced a health and social care strand within regeneration policy with the publication of '*A New Commitment to Neighbourhood Renewal: National Strategy Action Plan*' (Social Exclusion Unit, 2001: 27); '*The Department of Health has an objective to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. Targets will be developed in consultation with external stakeholders and experts early in 2001. The key measures in the NHS plan affecting deprived areas include: new incentives to recruit and retain primary care staff in deprived areas; the NHS plan sets out a commitment to make reducing inequalities a key criterion in allocating NHS resources*.' (SEU, 2001: 27).

The Neighbourhood Renewal Unit (NRU) became responsible for overseeing the central government's comprehensive neighbourhood renewal strategy. This strategy highlighted the need to respond to local circumstances rather than direct everything from Whitehall. It aimed to harness the expenditure of key government departments, rather than replicating one-off regeneration spending, encourage a range of different programmes to determine local need and pilot new ways to fight deprivation in the

poorest most disadvantaged communities (DoH, 2001: 9). By 2002, the Neighbourhood Renewal Unit had identified that one significant feature of the regeneration policy was the extent to which the emphasis of the policy had rapidly shifted in little more than two years since it was introduced. Regeneration funding had previously emphasised small, area-based approaches but this had changed to mainstreaming the programmes and strategic partnerships (DOH, 2002: 25). These shifts in the delivery mechanisms were acknowledged as being influenced by The Comprehensive Spending Review (Wanless, 2002), which recognised that successive phases of area-based initiatives had failed to reduce inequalities or achieve and sustain regeneration objectives. By 2002, the philosophy of a new commitment to regeneration, community planning and additionally Local Strategic Partnerships (LSPs) had been introduced and embedded (DoH, 2002: 160-163). The LSPs were designed to facilitate long-term partnerships formed at the level of the local authority. Working at this operational level was suggested as critical for the renewal of deprived areas, as the services, operational planning and making decisions about resources all operated at this level. Introduced to help coordinate the analysis, aims, objectives and targets of the local authority, the LSPs in the poorest neighbourhoods were to bring action to deliver progress (DoH, 2002: 14). It was suggested that the introduction of a knowledge praxis model as a dynamic, fluid process could help assimilate changed conditions, such as the restructuring that occurred because of the introduction of New Labour's multi-layered governance framework for regeneration policy (SEU, 2001), as well as the restructuring and financing of internal markets for health services (Ledwith, 1997: 141).

4.4: The impact of the Third Way ideology on welfare and regeneration

The New Labour government's political introduction of the Third Way was justified as a shift towards democratic decision-making, a move away from concentrating the responsibility with the providers of health services to a restructuring and modernisation of the delivery of health solutions involving local actors (Crowley & Hunter, 2005: 265-266; DoH, 2001). In the '*Tackling Health Inequalities: A Programme for Action*' of the Department of Health, there was an acceptance that health inequalities are '*stubborn, persistent and difficult to change. They are also widening and will continue to do so unless we do things differently*' (DoH, 2003). The emergence of evidence-based, public-health policy and practice acknowledged that the NHS had lost its way and had

been driven down the road towards health performance management (Lewis, 1986; Webster, 1998). The Faculty of Public Health introduced the idea that health improvement demanded skills from a range of agencies outside the NHS, some located within communities (Crowley & Hunter, 2005: 265-267). The need to tackle the health gap across socio-economic divides was acknowledged as one of the most important public health issues. Wanless report (2002) completed a comprehensive review of Public Health policy and advised the Treasury on future funding for the NHS until 2022 (Hunter, 2015: 573–4) and also suggested that investing in health was '*good economics*'. The Wanless report also suggested there had been a lack of sound evidence, underinvestment in research and development and an antipathy towards rigorous economic analysis of interventions to establish their cost-effectiveness. Wanless wanted to see the public consulted about the right balance between state intervention on one hand and a person's right to choose on the other. The Choosing Health White Paper (2004) outlined the government's Public Health proposals to rebalance the NHS from an ill health service to a healthy one (DoH, 2004). The policy's recommendations included leadership in public health, empowering the public to take more direct responsibility, local devolution, fewer centrally imposed targets, and making choices available to reduce health inequalities.

4.4.1: Structural determinants of ill-health and individual responsibility

In July 1999, the White Paper *Saving Lives: Our Healthier Nation* (Department of Health, 1999) set out the government's vision for improving health by putting citizens central to their own care. This paper put forward the idea of the patients themselves having the expertise and resources within themselves to manage more effectively their chronic, long-term conditions. The expert patients programme, successfully delivered, empowered people to manage their health conditions in the wider context of their whole lives. In the late 1990s, the Department of Health supported the Long-term Medical Conditions Alliance (LMCA) to work with national voluntary organisations, encourage information exchange and, most importantly, the use of lay-led, self-management programmes for people living with long-term conditions. Earlier service user movements had emerged, and by 1997 were well established. Their dissatisfaction with the services and support they were receiving, together with a sense of injustice helped them develop a new assertiveness and they presented new

political challenges to the welfare state and political establishment (Beresford, 2016: 176-183). These service user movements included mental health service users, people with learning disabilities, looked after people, older people, people living with HIV and disabled people. The expert patient programme (EPP) was developed in the USA at Stanford University by Professor Kate Lorig to encourage active citizenship and self-management using self-efficacy-enhancing techniques to potentially impact directly on the well-being of individuals living with a long-term, chronic condition (Bandura, 1997: 145-147). By 2001, central government's Department of Health Modernisation Unit introduced the Expert Patient Programme (EPP) under licence from Stanford University. Over the next five years the NHS EPP delivered programmes and built capacity amongst third sector organisations and Primary Care Trusts in England (Lorig et al., 2014: viii-ix). The health demographics within the NDC regeneration area had identified that approximately a third of the area population were living with some sort of long-term, limiting condition (NDC Delivery Plan, 2001: 35). The EPP was heralded as a new approach to chronic disease management for the 21st century and emphasised the need to raise awareness of self-management and empower patients to take a partnership role in managing their own health (Phillips, cited in Davies et al., 2013: 10-12). EPP was built into the NDC health focus group to maximise each individual's capacity and independence and to support the involvement of peers and volunteers in the provision of health care.

The Department of Health Modernisation Agency over the next five years successfully delivered this programme aimed at encouraging people living with long-term, limiting illnesses away from acute hospital care into self-management and community pathways, with their clinical care providers largely being the local general practice (Lorig et al., 2014: viii-ix). Sharing knowledge and enhanced decision-making between health professions and patients was a key feature of the programme, as was also building community-wide efficacy for social change and mobilising people who might have come to regard aspects of their lives, such as their long-term health conditions, beyond their control. The programme targeted peers and, through genuine community and institutional change, had a wider aspiration involving a shift of emphasis to people developing their talents and providing support structures to do things for themselves (Bandura, 1997: 500). EPP introduced models of training in systematic behavioural change into the local areas, with the NDC becoming involved in 2000 in EPP delivery

(NDC, 2001: 35). Neighbourhoods targeted the recruitment of volunteers to become peer educators, who it was assumed, in turn, would support collectives to self-manage their long-term conditions (Lorig, 2003). Ostensibly, this would help reduce the burden of increasing demands on the overstretched hospital services.

4.4.2: Targets, workforce and citizens

From 1989 to 2001, the NHS underwent four major reorganisations, starting with the changes heralded by *Working for Patients and Caring for People* in 1989. From 1998, a set of new National Service Frameworks (NSF) (DoH, 2000) were incrementally introduced across four strands of delivery (coronary heart disease, cancer, mental health and older people). Developing these national service frameworks and standards put the onus and responsibility on the commissioners to undertake external inspections and it was suggested that these strong accountability monitoring frameworks introduced across the NHS would help rebalance equity in the delivery of healthcare, set national standards and identify key interventions for a defined service or care group, with the goal of one new framework introduced each year (DOH, 2002: 87-90). Each NSF brought together a range of health professionals and partner agencies, commissioners and health service managers with the Department of Health supporting the management of the overall process. It was suggested that the NSF's were intended to address absolute and relative inequalities (Acheson, 1998: 7-8). This central government wholesale reorganisation and the new health strategies impacted on the organisational frameworks and infrastructures within which health was delivered. In April 2001, the Secretary of State for Health announced plans to shift the balance of power in the NHS. England's 95 health authorities were abolished and their functions taken over by Primary Care Trusts (DOH, 2002: 86-87). The main intentions behind this were to empower front-line staff and patients and change the structure and culture of the NHS. This additional legislation introduced by the Department of Health in '*Shifting the Balance of Power within the NHS'* (DOH, 2001*)* for the first time devolved the day-to-day running of the NHS to the front-line staff in the delivery of these improvements. This was intended to allow clinicians, patients and local community to be engaged in the decision-making that affected the local health services and the NHS to become more responsive to patients' needs (DOH, 2002: 87*)*.

'*A real shift in the balance of power will not occur unless staff are empowered to make*

the necessary changes. A cultural shift indeed will in many ways be more crucial to the success of the project than new management structures. Staff need to be involved in decisions which affect service delivery. Empowerment comes when staff own the policies and are able to bring about real change' (Department of Health, 2001).

Within two years of New Labour being in office, there had been an increase in the privatisation of welfare services, the NHS had introduced new hospitals funded from public-private finance under the private finance initiatives (PFI) and private companies were benefiting from illness (Weaver, cite Guardian, 15.01.2003). In terms of policies, such as Wanless *Choosing Health and the introduction of expert patients*, it could be debated that the focus of choice and individual responsibility was a means of deflecting attention from the structural determinants of ill-health and to apportion responsibility and blame to the individual actors.

4.5: Conflict arising from introduction of New Labour PPFIs/LIFT

The first Private Finance Initiative (PFI) was a controversial and little-used mechanism established by Norman Lamont to privatise specific construction projects under John Major's Conservative government in 1992. Together, the public and private sector identified construction projects to be financed through PFI, which entailed fixed payments over a period of approximately 30 years (Nelson cited in The Spectator, 17.9.2008). Whilst Edwards et al (2004) quotes Alan Milburn, (Secretary of State for Health,) in 2000 *'Let me say at the outset that partnerships between the public and the private sector are a cornerstone of the Government's modernisation programme for Britain. They are central to our drive to modernise our key public services. Such partnerships are here, and they are here to stay'*. Edwards et al (2004: 133:140) suggested that under New Labour, the PFI scheme became a beacon for the Third Way as a means of incorporating the ethos of the private sector into a declining public sector. Shaw (cited in Hales et al 2004) proposed the strategy involved a separation between the role of commissioning of public services which remained under the responsibility of the public authorities, and the role of providing those services, which the private sector was encouraged to undertake. It was described as the '*key element in the government's strategy for delivering modern, high-quality public services* '. By 2001, three years into the NDC delivery programme, central government had introduced a range of new Public Private Finance Partnership Initiatives (PPFIs) with

reference to potential activity into health estates within the area-based initiatives. The health research Institute, Boyle and Harrison calculated that, by the end of 2002, the majority of the NHS capital investment projects would be financed and managed by the private sector (Boyle & Harrison, 2000). New Labour suggested PPFI was indispensable to the NHS modernisation and its survival as a free and universal service providing health care based on clinical need. The PFI was adopted as a way of funding public capital projects such as NHS hospitals with a total capital value estimated at nearly £13 billion and by 2016 across England there were 127 schemes (NM Treasury and Infrastructure and Projects Authority, 2016). The Treasury Department policies related to these PPFIs and the newly established Local Improvement Finance Trusts (LIFT) that were introduced into the NDC area-based health reconfiguration adopted a different culture regarding the approach to and the participation of citizens. Public information leaflets distributed to the statutory partners explained how the Department of Health had entered a national joint venture with Partnerships UK plc, which was established by the Treasury in 2000 to facilitate the development of local Public Private Partnerships (LIFT, 2001). These Public Private Partnerships were presented as a method of joint working between the public and private sector in the context of addressing problems within the current investment process within primary care. The literature to develop the local LIFT identified £175 million as government funding and suggested future on-going management by the Treasury into the provision of Primary Health Care locally.

'*LIFT would give flexibility to GPs who do not want to own their own practice property. The LIFT will assume responsibility for managing and implementing agreed investment and service, but also for planning for future estate and service requirements to meet the local economy needs and developing opportunities identified by the private sector partner*' (LIFT, 2001: 3).

However, in the initial consultation meetings affecting the NDC area, PPFI were badged as the government's new primary care initiative, aimed at improving existing primary care facilities and also providing patients with '*joined-up'* services. Three years after the NDC had commenced working on health provision in the area-based programme in partnership with the community, the Treasury PPFI was introduced to the local region. It was promoted as a scheme to provide funding by involving three partners: the private sector; the local authority, and an organisation comprising the

PCT, dentists, GPs, pharmacists and opticians, who were identified as the '*local stakeholders'*. From its inception, the PPFI did not extend the culture of democratic engagement towards local citizens and there was a lack of transparency about the various financial interests after agreement had been reached and a commitment had been made to use LIFT funding. (LIFT stakeholder minutes, 2001).

Two years into the research, the NHS and local government widened its range of PPFI across the region that had area-based initiatives, and further strengthened its partnership arrangement with the private sector developers. The NDC policy monitoring body was housed in the Office of the Deputy Prime Minister, the PFI initiatives emanated from the Treasury department and the health and well-being policies came out of the Department of Health and the Home Office. These central government departments had separate administrations and approaches across each administration (Downe & Martin, 2006: 465-471; Jordon, 2010.: 27-29), and different departments had different terminologies and cultures with little or no reference to the other department's agenda or how they would coexist or work together. This was at the time when neighbourhood locality working was being established as a developing strand of New Labour's NDC policy, with its central theme of strengthening involvement and participation within the local democratic community. However, it was evident that strengthening local people's voices, at times, was in direct conflict with some of the other policies that were coming out from different departments of the central government, and this aspect is explored further in Chapters 6 and 7. The legislative changes around the Neighbourhood Renewal policies (Department of Health, 1999; Department of Health, 2000) consistently reiterated the principle that local people know best about their priorities and the needs of their own neighbourhood (www.neighbourhood.gov.uk). However, the NDC/NR policies, that is, the Treasury policies related to LIFT or PPFI, did not adopt this participatory citizen approach. Williams (2017) suggests that the relationship between the state and the citizen, in theory, is one of equals. Whilst the state might be bureaucratic it is also accountable. However, the cultural norm within the emerging PPFI's appeared to regard the councils and the contractors' interests as completely synonymous and regard the tenants as beneficiaries. Within this partnership, civic engagement was lost; '*something serious happens to local democracy when it enters into a convoluted pact with a global corporation: accountability becomes monitoring, dialogue becomes a*

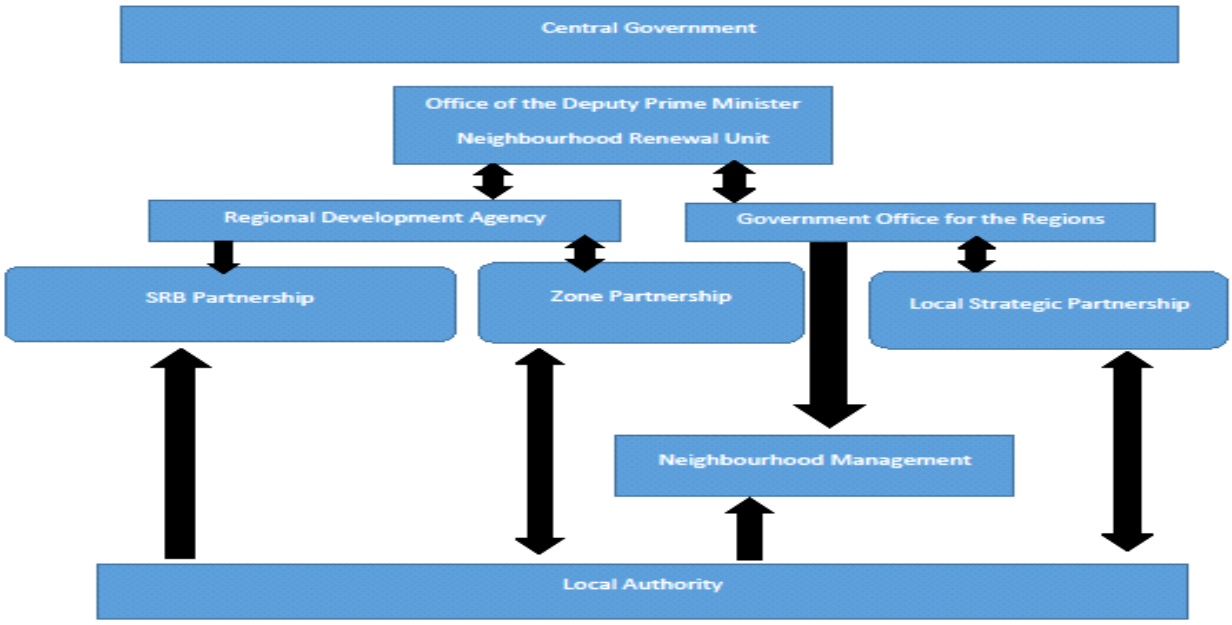
directive, communication becomes PR, representation turns adversarial, transparency stops short of real openness' (Williams, 2017). New Labour's Third Way had suggested the need to prioritise responsibility over rights and acknowledged the need to develop greater social cohesion within neighbourhoods (Giddens, 1998: 65-7). The Third Way's articulation of reality had participatory citizenship interpreted as an attempt to harness social capital, to positively embrace the private sector in the market economy, but whilst policymakers expressed considerable interest in harnessing social capital, they often concentrated more on the monitoring of targets (Field, 2003: 116-119). New Labour defined citizens as 'good' and 'bad' citizens and shifted responsibility from government to the social sector and ultimately to the individual citizens themselves. However, New Labour did not undertake an equivalent shift in the rights of political participation or economic power for those same citizens (Hale, 2004). By Labour's second term of office, the widespread introduction of the public-private finance initiatives, together with a multiplicity of contractual arrangements, had contributed to a fragmentation of overall service provision and impacted on reducing local voices and transparent democracy (Shaw, cite Hale, 2004: 80-82).

4.6: Greater coordination and 'joined-up' policies

The new neighbourhood renewal / regeneration policies introduced post-election were highlighted as a focus for change, and upheld and defended as a new opportunity for improved partnerships between state and civil society. Neighbourhoods received greater attention from politicians and policymakers, with targeted area-based initiatives being identified as the spaces where fragmentation could be reversed by combining networked, organisational approaches and community governance (Newman, 2001: 99-102). Complex multi-level governance is defined as '*negotiated non-hierarchical exchanges between institutions at the transnational, national, regional and local levels (which) do not have to operate through intermediary levels but can take place between, say the transnational and regional levels, thus bypassing the state-level'* (Peters, 2001: 132). Blair purported to have introduced this '*multi-level governance*' into the newly created Local Strategic Partnerships (LSPs), by incorporating new sets of administrative targets, and managerial regulations involving partnerships between the public and private sectors (Clarke, 2004; Jordon, 2010: 197-203) (see Figure 4.1). Newman argued that, in fact, these top-down controls from central government required continuous audit monitoring and, by providing incentives

for information, contracts became the key elements in influencing individual behaviour and promoted a '*checks and balance*' culture (Newman, 2001: 84-86). Analysis of health regeneration programmes introduced prior to New Labour's term of office had identified tensions arising related to the introduction of these multi-layered networks, which were politically directed by central government and overseen by local government, because of the fundamentally different roles each play (Painter & Clarence, 2000). When the local actors have, in theory, been given more participatory power to manage the processes within the developing networks, this raises additional complex issues related to active management, communication and power-sharing (Diamond & Liddle, 2005: 132-134). This research acknowledges and investigates further these multi-layered governance dynamics, using the data collected from the research respondents and presented in the analysis chapters of 6, 7 and 8.

Figure 4.1: Multi-Level Governance Framework for Regeneration Policy



Source: Adapted from Social Exclusion Unit (2001).

The Policy Action Team 17 (SEU, 2000) focused on how to get initiatives and partnerships developed and actors working together at a local level. They identified a need for greater coordination to pull together complex and fragmented planning and to develop service-delivery frameworks. The LSPs focused the new policies on funding and targets, including strategies to tackle worthlessness, weak economics, crime, poor

health, housing and improving the physical environment. Additionally, a raft of '*floor targets'* were also introduced to focus on raising the standards in the worst performing areas of government intervention. This strategy was intended to focus on '*joining it up locally'* with local coordination and community empowerment using the LSPs and neighbourhood management, while the regions and central government were to provide leadership and support (SEU, 2001). This introduced a system of multi-level governance within regeneration policy, with the dominant narrative of central–local government relations enshrining the power of central government giving them the ability to affect policy competencies and limit the autonomy of local political institutions (Pratchett, 1999). The advancement of multi-layered governance was designed to increase the opportunities for devolved local authority from national levels. However, Newman (2005a) suggested that new players entering the social policy field produced new dynamics and new structures of governance that need access and communication. She suggests access to information and knowledge is critical for participation and inclusion, and this process is often limited to government organisations and existing societal stakeholders. This then reinforces the previous transitional pathways and further marginalises civil society and non-government voices (Newman, 2005a: 217). Public entrepreneurialism, operating reflectively and strategically within the newly emerging government structures, was also actively encouraged within New Labour's Third Way policy to reinforce notions of an individual's agency (Catney, 2015: 1327). This focus on public entrepreneurs encouraged them to operate reflectively and strategically and use the government structures framework for their actions. However, Catney suggests agencies worked within the wider structural and institutionalised contexts, which highlights the importance of multi-layered governance both as a constraint, but also as an opportunity. Hunter examined the new spaces cited for an introduction of a new public health in the NHS plan (Department of Health, 2000), a plan which recognised a need to replace the outdated anarchical nature of the current health service (Crowley & Hunter, 2005: 265-267). The understanding that the nation's health is not seen solely as the preserve of the medics was also reinforced in policy publications such as *Saving lives: Our Healthier Nation* (1999) and *Bringing Britain Together* (1998) which all reinforced and helped signal a new understanding of the government's part in shaping a healthier society.

Ledwith (2010: 41) identified participatory practice within the lived experience of involvement at each layer, contesting that the impact of joining up, vertically, horizontally and cross-nationally was transformative, and described how the introduction of the new regeneration policies saw paradigm shifts within the contexts of community participation. However, Jordon contested that the Third Way's notion of equality of opportunity followed on from Thatcher's blend of individualism and hierarchical management, and represented a reinterpretation of fatalism coupled with more individualism (Jordon, 2010: 193-194).

4.7: The implications of the Third Way for health and social-care services

4.7.1: Centrally controlled - locally delivered

In 2000, the NHS Plan Implementation Programme (DoH, 2000) set out a vision of the health service designed around the patient. The NHS Plan offered a process for developing plans locally and modernising services to support a framework for reviewing health improvement plans, monitoring and agreeing the services, financial frameworks, joint investment plans and primary care investment plans, linking local health and authority structures together by 2001.

These targets and milestones were to be managed and reviewed centrally and updated by the Department of Health Modernisation Board (DoH, 2000: 1-4). The introduction of the new Health Improvement Plans (HImPs) and Joint Improvement Plans (JIPs) to local authorities were also intended to link local voluntary and statutory efforts together with the joint planning and delivery of health and well-being strategies. These strategies required the pooling of budgets and impacted on the reorganisation of local government and the NHS, with the individual plans being replaced with a single, 3-yearly Local Delivery Plan (LDP) (DoH, 2002: 90, 2.1).

Stoker (2005) identified these policies as a central government model of '*joining up*' skills with the local authority by using strategic community leadership in partnership with political autonomy. This offered the local government management, but had the central government setting the political agenda (Stoker, 2005; Leat et al., 1999). The local strategic partnerships (LSPs) emerged in the late 1990s as part of government strategy for 'delivering responsive, coordinated and efficient public services and producing community plans' (Davies, 2009: 84). In an early analysis by Elston et al.

(2002) of the HImPs and the JIPs, they pointed out that the health improvement plans had developed structures, rather than processes, locally delivered and centrally monitored. So whilst the HImP was considered a good joint-planning model at a local level, the initial findings indicated it had poor representation from community groups, service users and carers. Skidmore (2006), in the Joseph Rowntree foundation study, identified that whilst consultation was taking place via the newly constituted public meetings, there was still a notable lack of transparency with regard to the resource allocations and the ownership, and one key factor in influencing levels of participation in governance was the existing patterns – those already well-connected – tend to get better connected (Skidmore et al., 2006: ix).

4.8: Conflict arising from the reconfigured health and social-care systems

4.8.1: Workforce

New Labour introduced its policies immediately after it came into power, irrespective of the actual availability of the capacities or skills that people required to deliver the new agenda.

'*Regeneration management is governed by mandates and the funding regime is quite different from those they may have been familiar with. Hierarchical top-down bureaucracies have been replaced by more flexible and networked organisational forms, many requiring a whole new set of skills, competencies and expertise to deliver the modernised agenda. Multiagency professionals are increasingly required to work beyond their own organisational professional boundaries in partnership and to pool resources and effort to achieve commonly agreed regeneration objectives*' (Diamond et al, 2005: 25).

The regeneration agenda was required to work alongside the NHS and the Community Care Act (1990), under which health and social-care partnerships had undergone major reconfiguration and decentralisation. The introduction of the purchaser-provider split, the internal market and the dynamics of decentralisation are some of the major structural changes that occurred in delivery of health services. Healthcare organisations had been reconfigured under the Conservative government to become NHS Trusts, and, as such, were already independent organisations with their own

management structures.

Public participation was extoled as a means of raising standards and ensuring the best possible fit between local services and need. Establishment of the NHS trusts offered opportunities to 'improve the experience of patients' in the NHS, with local health structures working with the representative democracy in citizen-based panels, juries and patient partnership programmes (Barnes et al., 2007: 22-25). By 1998, the introduction of the Patient's Charter was one example of a top-down style consumerist model with people being instructed about their health expectations versus a bottom-up approach based on individual expectations and perceived needs. While the NHS had been service-orientated and isolated from local people, health had been interpreted through the narrow prism of ill-health. The Wanless report (DoH, 2001) was critical of the failure of policy, in particular in addressing the imbalance between state intervention on one hand and a person's right to choose, and the report emphasised the importance of generating a greater feeling of local ownership and supporting social cohesion within communities (Crowley & Hunter, 2005: 265).

By 2000, the NHS had reorganised its regional District Health Authorities and Community Trusts. The Primary Care Trusts (PCTs) were operating as commissioning, purchasing and management entities, along with their provision of health services to local district populations (DoH, 2001). In the acute hospital sector, from 1998-2001, the reconfigured individual management structures of the Hospital Foundation Trusts also began emerging onto the health service landscape (Gorsky, 2008). These NHS trusts were encouraged to support creativity and innovation and to challenge hospitals to move more service delivery to locations within the community. With the emergence of the newly formed Acute Hospital Trusts, greater participation in shared management of their condition with people with long-term conditions was another additional objective. Through the initial phase of the neighbourhood renewal programme, the NHS trusts were encouraged to be extremely supportive and, in some instances, to act as the main health contact (DoH, 2001: 93).

4.9: Participation, Individualism and Collectives and economics

The Centre for Economic and Social Research (CESR), in Phase 2 of the NDC national evaluation, highlighted that the origins of the NDC's programme lay in the 1998 comprehensive spending review, which informed the Social Exclusion Unit's

report *'Bringing Britain Together: a National Strategy for Neighbourhood Renewal*' (SEU, 1998). It argued that, despite many years of area-based regeneration policy, there remained at least 4,000 seriously deprived neighbourhoods in England (Lawless, 2007: 2-3). Critical, reflective analysis of the social policy and political contacts suggests that this theoretical academic approach to social capital was introduced in 1998 by New Labour out of an economic imperative, to harness civil society's involvement in order to address the preceding decades of health inequality.

'*Local government, as well as community organisations, have increasingly been involving local people in the development of local strategies. These community plans force local authorities to think about local economy, sometimes for the first time! The need for local community plans is also changing the way the economic thinking happens.…Community involvement works well for decisions with which people feel comfortable – location of health facilities, standards of education, timing for workshops and so on. However, we have found many if not most people are turned off by economics* (Ward & Lew, 2002: 8*).*

However, Boyle (2006) suggests that institutions will only throw their weight behind participation when they can see the real benefits that taking a different approach can deliver; evidence available from evaluation and action research that shows the kind of health impact and benefits that participation can produce*.* Boyle highlights some of the complexity in evaluating participation and introduces concepts of co-production. Additionally, the report highlights the impact that institutions can have, depending on their willingness, to wholeheartedly engage in involving local people in finding their own solutions *(*Boyle et al., 2006: xiii-xiv).

In reviewing which policies supported the targeting of greater participation of local citizens, New Labour's direct legislation (*Shifting the balance of pow*er', DoH 2001) was intended to increase the participatory involvement of front-line workers ostensibly to strengthen the operational decision-making in health and welfare. However, the work of Mackian (2003) suggests that a complex recurring concept was, in reality, a rhetoric introducing '*public health'* focus on '*partnerships*.' '*Partnership working is now a mainstream activity for local government and the NHS' (*DoH, 2001a: 2). These partnerships were intended to share good practice and pool skills to facilitate inter-agency working around a social model of public health; liaison with social workers and

numerous health professionals where building trust was an essential part, and which demanded professional and personal input (Mackian, 2003: 223-227).

Shifting the Balance of Power within the NHS (DoH, 2001) was introduced by the Department of Health to support front-line staff to deliver the improvements and to empower them to make the decisions locally. However, the reality is that the introduction of this policy coincided with the front-line clinical workforce within the communities being transferred from their previous employment within the previous community trust structures into the newly formed PCTs. This was a time of low morale, confusion about roles, transition and change within front-line staff and at the same time new, tactical, line-management structures were emerging (Diamond et al., 2005: 10-15). Within the newly formed PCTs, the front-line health staff were being encouraged to extend their roles, to work outside of the boundaries of their previous clinical parameters and, additionally, to support patients and local residents to maximise their own independence (DoH, 2001).

Front-line staff, who in some instances required additional training to play these roles, were being encouraged to develop new responsive relationships and interactions inside of the communities they worked in. The policy placed the onus of the responsibility for the success on the tactical and front-line staff, who were encouraged to make local decisions and utilise their public-health skills to address health inequalities by working directly with patients (MacKian, 2003: 224-226). This enhanced clinical relationship was to produce a shift in decision-making towards empowered clients, although encouraging partnerships was a new role for most front-line staff (DoH, 2001).

Models of communication as an integrative process involving community dialogue and collective action, working together to produce social change and improve health and welfare, was not considered new (Figueroa et al., 2002: 2-6). The critical analysis (DOH, 2001) of the health improvement and modernisation projects introduced by central government identifies that, whilst the centralist legislation purported to give permission for more decisions to be taken by front-line staff and local people, this legislation was implemented inside a context of the simultaneous restructuring of health and social care with increased monitoring and control from both central government and local commissioners (Community Care, 2002; Diamond et al., 2005:

116-122).

Also in 2002, other major structural changes within primary care occurred as the new general practitioner (GP) contracts introduced the beginning of the '*purchaser provider'* split with the first wave of these fundholding (GP's). Popay proposed that the rationales for the introduction of these organisational changes, the increased economic control and the development of the new health pathways, included:

'*concerns over the cost of GP prescribing and gross variations in referral rates; concern over the poor quality of practice premises and of the clinical care provided, (often poorest in areas where needs are greatest); concern over the lack of coordination between GPs and hospitals, between GPs and other health professionals, and between health and social care'* (Popay & Williams, 1999: 972-973).

The demographics of the NDC geographical area identified that there were only two full-time GPs and one part-time GP servicing the area-based population of 9,750 people from two poor sites (NDC, 2001: 13). Gillam (2006) highlights one of the impacts of the changes in the NHS from 1997-2006 included a growing lack of faith from the front-line clinicians and a mounting distrust of the central government's lack of transparency in policy-making:

'*This centralist and controlling administration always seem likely to crush the NHS under the weight of good intentions. 'Shifting the balance of power' soon became devolved by devilish detailed directives. The hands of Primary Care Trust executives were tied by voluminous sometimes conflicting, guidance. An enormous gulf exists between policymakers and the front line, but Primary Care Trusts could have been given greater discretion to establish their own objectives. Staff will never own targets that seem to reduce the complexity of their everyday encounters into 'bean counting*' (Gillam, 2006: 253-254).

New Labour's Third Way had introduced policies and health-service restructuring and local governance models ostensibly to introduce greater partnership and participatory working. Criticised by Gillam (2006) as a failure, the changes proposed in the White Paper, *Shifting the balance of power* (DoH, 2001), were experienced as centralist interference within the NHS, introducing yet more layers of control and administration which were beset by bureaucratic monitoring and targets, rather than actually

increasing ownership by the front-line workers. Dean suggested that the study of dynamic systems involving chaos and complexity theory would offer new ways of thinking to facilitate an understanding of the interplay of influences and processes shaping health and illness (Dean, 1993, cited in Popay et al., 1998c: 628). Evidence-based public health interventions had previously driven the front-line workers' clinical roles, which were guided by predominantly qualitative, published, evidence-based medicine and research. In 1998, understanding this complex terrain of the new public health policy and practice and how spaces encouraged health gain had not being widely analysed or acknowledged (MacKian, 2003: 219-229; Crowley, 2005: 265-267; Popay, 2003: 1-23).

4.10: Conclusions

This chapter provides an overview of recent changes in health services and explores the contradictions within the Third Way policies introduced by the New Labour Government between 1997-2004. It establishes the context of the area based initiative experienced by the local actors that the New Deal for Communities (NDC) regeneration programme was introduced into. This chapter introduces the social and political environment, and outlined the restructuring of health and welfare services, the impact of central control and the experience of the delivery of the regeneration programme locally by the community (Elliott & Popay, 2000: 461-462; Macaulay et al., 1999: 774). This includes a reconfiguration of the hospitals and voluntary sector (DoH, 2001: 83-87) and the policy and legislation which was introduced to potentially encourage participation from the front-line workforce's involvement (DoH, 2001) to deliver on the '*new public health agenda*' and to help ameliorate health inequalities. The newly commissioned health and well-being structures are introduced, which substantially increased the requirement for increased tactical monitoring and reporting returns to central government. Parallel across this timeframe, a global financial downturn was impacting on the ability to resource the health and welfare services. This downturn was further compounded by the dynamics of central government's interdepartmental conflicting policy and legislation directives. Whilst extolling the need to introduce partnership and 'joined up' working at structural and local level, centrally the different departments, Department of Communities, Department of Health, Modernisation Unit, Public Health Department and the Treasury department, appeared to be working in silos. The former Prime Minister, John Major, commented

on the themes suggesting they were built on earlier Conservative reforms and that he '*did not appreciate at the time the extent to which Blair would appropriate Conservative language and steal their policies'* (Alcock et al., 2012: 140). These changes in social policy Alcock suggested resulted in:

- A large increase in expenditure in the NHS that brought it into line with spending levels of other European healthcare systems;
- New monitoring institutions such as the National Institute for Clinical Effectiveness advising on cost-effectiveness in the NHS and regulators such as the Health Care Commission;
- Significant change in the area of welfare pluralism increasing the private funding and provision of social policy;
- The promotion of choice and consumerism; and
- The future 30-year 'mortgage' and reconfigured financial control incurred associated with the private finance initiatives (Alcock et al., 2012:140).

The Third Way policies emphasised, amongst other things, individual rights, responsibilities and self-help, alongside a reconfiguration of health and welfare structures locally and nationally, assuming that '*social capital'* leads to social cohesion (Ledwith et al., 2010: 49). Jordan suggests in analysing why the Third Way failed, that under New Labour government public finances switched to massive borrowing from world money markets (Jordon, 2010: 2).

The thesis has interrogated the introduction of the national regeneration policy and the reality of joint participation of the local actors within the new democratic spaces and the community governance models that arose as a result. The overview of the literature review confirms that the NDC policy environment was messy, contained multi-layered governance, and non-linear dynamic systems with the interactive relationships resulting in complex variables within the changing delivery of the health and social care systems (Zimmerman et al, 2001: 262). Whilst New Labour Third Way may have introduced participatory joint working within the local community, its impact on health inequality in the deprived area is inconclusive, suggesting that there was a continuation of top-down imposition rather than the encouragement of bottom up participation.

The literature suggests that the Third Way regeneration programme was primarily a continuation of the previous Conservative government's neo-liberal, market policies to restructure health and social-care services through privatisation, rather than the introduction of a participatory framework into the area-based initiative to deepen democratic involvement. This social policy and political context helped determine the research strategy and methodology used to collect data to meet the research objectives. The thesis data analyses citizen involvement and participatory governance models, describes the new democratic spaces and documents the changes that emerged in the NDC over the longitudinal time framework. The thesis focus on the social, political and policy environment examined in these last three chapters helped determine the research strategy of directly exploring and examining local actor's views and their capacity to participate in the implementation of the NDC programme. As an insider researcher, I have acknowledged the effect of unequal social relationships, power and influence on the respondents. The distinctive '*inside voice*' and '*way of knowing*' generated by this qualitative research makes this a unique contribution (Popay & Williams, 1998b: 36).

5: Methodology

5.1: Introduction

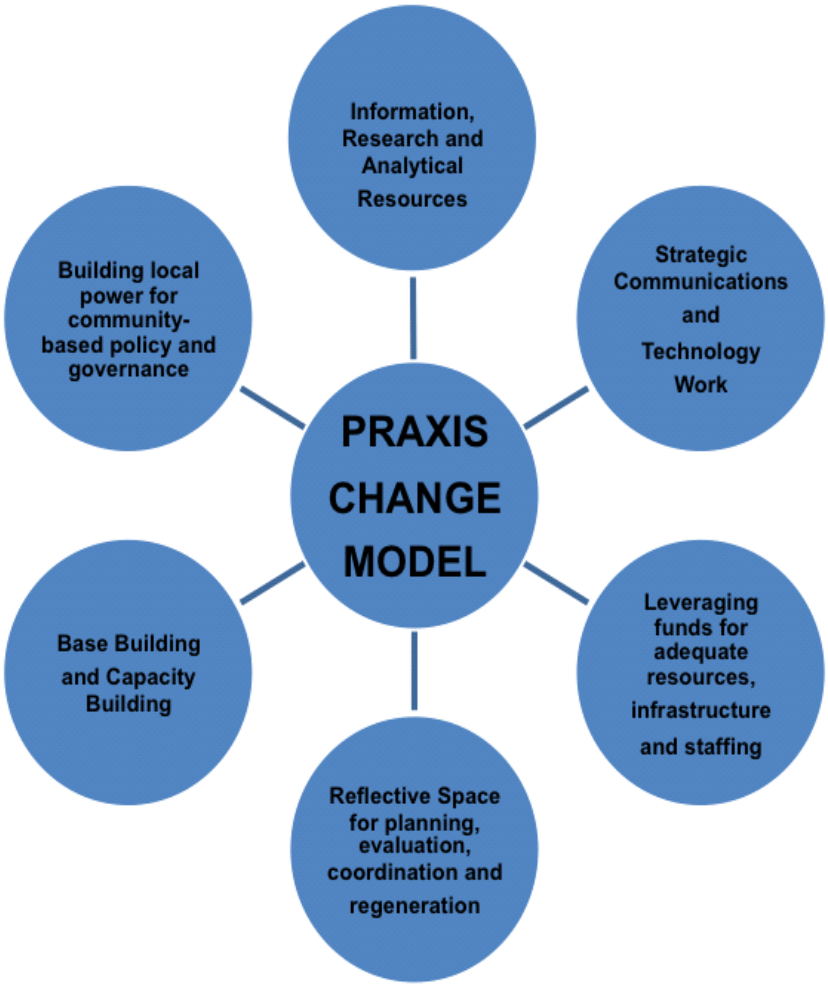
This chapter describes the chosen research methodology and introduces the tactics and processes used to develop the contours of the final research strategy. My research question sought to understand the local actors' views on their involvement and participation in delivering the regeneration area-based initiative (ABI) agenda. I discuss why I chose my research philosophical approach; adopting a deductive style which involved action learning methods and mixed methods to collect the data over a longitudinal timeframe. My research interrogated the perceptions of the participatory experiences of a small number of actors within one specific geographical area-based initiative chosen from an operational, tactical and strategic domains and I exercise caution regarding the generalisability or transferability of the results. The data collection started as New Labour regeneration policies were introduced in 1998/9 with the final data collection in 2007/8. The research methods used had to effectively collect and analyse data on the local actors' views of the changes in community governance and local participation in the health and well-being agenda as the NDC policy was introduced. The thesis examines the impact that the Third Way Labour government centralist policies, introduced from 1997-2004, had on community participation. The data collection and analysis acknowledges the complex social and political environment and local actors' experiences of the participatory NDC regeneration policy, and the impact of other central government policy decisions introduced by New Labour. Jary and Jary (1995: 147) explore Gidden's theory of structuration, suggesting it was an ambitious theoretical attempt to transcend the dualism and the rigid separation of '*structure and agency*' using an analytical, independent analysis of private aspects of the social world rather than an internally related and mutually constructive one. These epistemological and ontological concerns influenced my chosen methodology, and the data collection. I used a community-based, participatory research approach (CBPR) involving a philosophy of engaging with the communities, reflexive action, and a research approach where multiple methods were used. Community-based, participatory research includes: working with the community living or working within the area-based initiative; focusing on strengths and assets rather than needs; integrating knowledge and action in order to create change; promoting an environment for co-learning that addresses social inequalities; involving critical

reflection and cyclical processes; and addressing health from a positive ecological perspective. In addition, all the knowledge is being disseminated to the partners to support transformative outcomes (Becker, 1998; Malone et al., 2013: 205)

5.1.1: Context and the Model of Praxis

The chosen methodology aims to critically capture the inside voices and opinions of a small sample of local NDC actors, to explore the inside data over the whole of the longitudinal timeframe at the inter-subjective praxis where efficacy and subsequent collective action occur. It was as the insider researcher between 1998- 2004 working in the NDC programme that I acknowledged the dualism of both the macro- and micro-elements that impact on citizen participation. My research study is positioned inside the knowledge praxis, to analyse fifteen respondents' views involved from inception on the implementation of new NDC, participatory policies. This model of praxis is intended to help locate action within a wider structural analysis to determine the extent to which local actors were primarily supported and the level of individual and collective involvement within NDC health programmes (see Figure 5.1). It supports a reflective space and a framework for understanding policies, the social determinants of health and a civil society empowered to facilitate a change agenda (see https://www.thepraxisproject.org). I used Ledwith's model (1997: 95-8) as it offers a structure for critical pedagogy to help simplify complex situations.

Figure 5.1: Change Communication Model



Source: Adapted from https://www.thepraxisproject.org/2017

Chapters 2, 3 and 4 introduced the complex dynamics which were present in civil society, the health and well-being services and the centralist political ideology as New Labour's NDC regeneration policy was introduced. These inter-relational dynamics within the area-based initiative were important to acknowledge when researching the features which influenced the local actors' involvement as partners in the delivery of the regeneration programme over the longitudinal timeline from 1998 until 2004. The centralist, macro, Third Way political policies impacted the capacity of civil society to fully participate, and the statutory, public, voluntary and private sector all influenced the delivery of the programme as did central government's on-going introduction of competing policies and legislation across various departments. The meta- and micro-operational analysis of the NDC health environment, as it influenced active participation over time, is documented in the

respondents' transcripts and contemporaneous notes.

Recognising the emerging models of participation and community development is important to this research, as these were interpreted through the prism of the changes introduced by the Third Way New Labour government and the subsequent impacts on social capacity. This longitudinal research is located at the introduction of New Labour's Third Way and how the metric of community development was incorporated into social capital theory.

The initial analysis of the wider environment's social and political context enables me to argue that the research was grounded in praxis. I observe and analyse across the longitudinal timeframe the strategic influence of the centralist political agenda and the direct impact on the tactics of community respondents. The thesis captures the new emerging democratic, joint, decision-making spaces that developed as a direct result of implementing the NDC programme, such as the health focus group forum. The research offers opportunities for documenting and analysing the reflections and actions of the local actor's in what amounted to a critical dialogue (Ledwith, 1997). The data collection capturing this critical dialogue used action learning and reflective naturalist approaches (Revan, 1966; Schon, 1983; Guba & Lincoln, 1981) which I introduced to the NDC respondents. The research acknowledges that the introduction of policy to increase system involvement and citizen empowerment cannot be considered in isolation, and explores how to make changes to give people greater control (Beresford & Croft, 1993). The research strategy methodology was guided to purposefully select the specific respondents, as they had all been involved since the inception of New Labour's NDC policy, and represented data from the operational community and the tactical front-line workers and strategic actors' perspective. The respondents all became involved in the NDC programme during the years 1999-2004. I acknowledge this samples percpective did not document the views of actors who became involved in NDC after it was established. The analasis chapters however document the conflict and dissension arising at times as a result of the different actors entering the programme after it commenced.

Previous chapters focus on the restructuring of health and social-care services and identified some of the impacts on the localism and inequalities agenda which New Labour introduced. The introduction of greater participatory democracy and the

changes which arose from the various central government, health and well-being policies and legislation, are recorded alongside this strategic, tactical and operational local reorganisation and the changing, health service frameworks within the local government and health sector.

5.2: Strategy and research design journey

Developing the conceptual framework and the strategic planning for the research began in September 1999 when I first became involved in an audit of public involvement and public empowerment with the local community stakeholders, on behalf of the HAZ. It was also in a similar timeframe that public health began introducing concepts of action learning and reflection in small clinical group spaces, to develop evidence-based outcomes and improve practice (NICE, 2008: 65. Scutchfield et al., 2006: 76-78). The NDC Pathfinder bid was also introduced at this time to the key stakeholders, and my chosen research area became enhanced joint working and participation between front-line workers and local people. Gaventa (2006a: 4-6) questioned and analysed the '*power*' and the '*spaces*' and opportunities for emerging citizen engagement in the policy process. Shaped by my own history and grassroots work within deprived areas with high incidences of health inequalities, I questioned how an ABI could support enhanced participatory democratic engagement. Questioning the most appropriate way to support the engagement of the local actors participating in the planning of the NDC Health Focus Group (HFG) was my starting point. Cornwall and Schattan Coelho's work (2007) reminded me that the created spaces and opportunities were often not neutral spaces, and the '*invited*' spaces or '*closed*' spaces offered opportunities where the local people could potentially have meaningful discourse on the decisions and the relationships that affect their lives and interests. However, simply creating spaces does not ensure participatory engagement. Cornwall and Schattan Coelho (2007) discussed how citizens on the receiving end of paternalism or prejudice in everyday encounters may bring these attitudes into the participatory sphere. Alternatively, I needed to understand '*the power dynamics'* of encouraging engagement in actors who have been silenced, which may influence either their agency or voice in a participatory space (Cornwall et al., 2004: 10-12). To allow opportunities for wider thinking, in 2000 I enrolled into the Revans Institute at Salford University and within the NDC 2001/2 I began using my action learning set to understand and reflect on my work, while also keeping journal notes.

Revans (1966) pioneered action learning as a new technique for scientific management and organisational development, and the use of action learning in the National Health Authority. In the northern city where the area-based initiative was located, the university had an Action Learning Technology Department, founded by Professor Reginald Revans (1907-2003), a key architect of action learning. It was Revans' formula L = P + Q (Learning = Programmed knowledge + Questioning insight) together with the principles of action learning research (ALR) that guided my research direction and community action learning sets. Working within my action learning set with the other group participants asking insightful questions about the complex situations involved in implementing the NDC helped me to reflect and clarify my research focus. In supporting local participation for local citizens to engage in the delivery of health policy meant that I examined the opportunities where citizens and key stakeholders could come together. The implementation of the regeneration policy presented potential opportunities for new spaces for change where local actors could explore health needs, inventory current services and develop their own actions looking at the transformative potential. If the participatory sphere was to be genuinely inclusive, allowing actors to participate meaningfully in a complex set of interactions, then using design principles which stimulated '*participation from below*' was critical and this needed to be addressed in my approach (Cornwall & Schattan Coelho, 2007 p. 8). This reflection helped formulate my research strategy, which was to collect the data from the spaces that the local actors met and had meaningful discourse, and to explore whether the introduction of New Labour's policies had improved opportunities for community participation. I identified these as the ALS, Health Focus Group (HFG) and Community Action Partnership (CHAP) spaces.

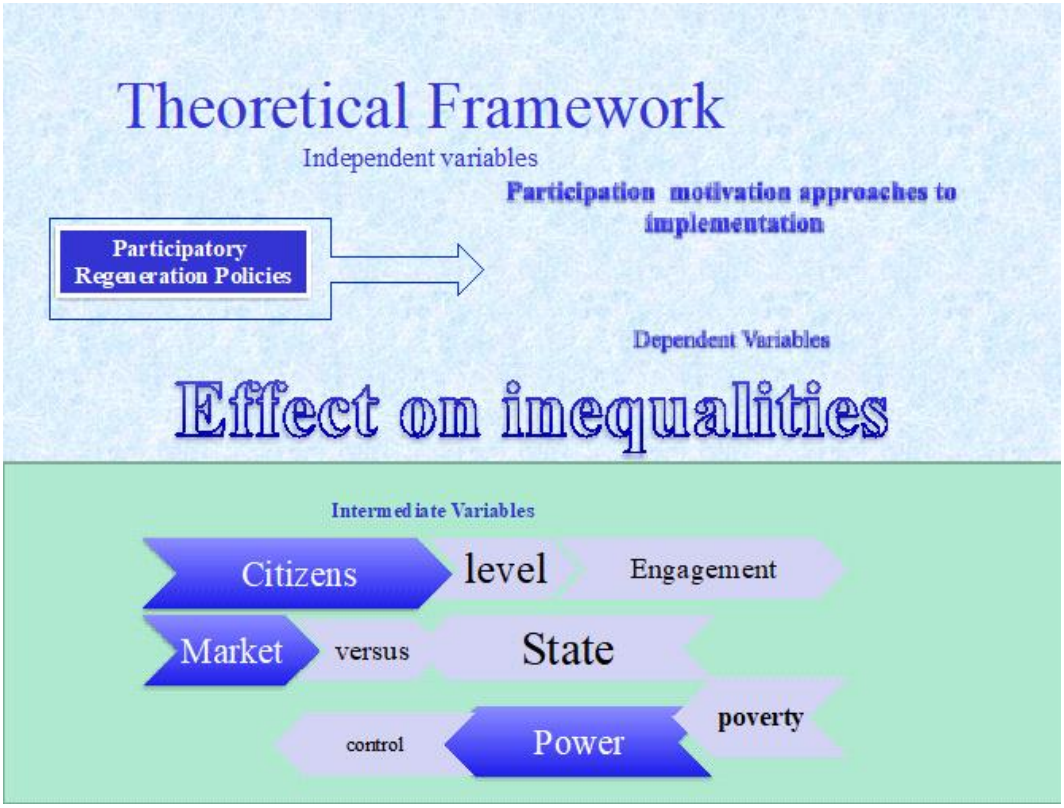
Between 1999 and 2000, my initial role was as a public health practitioner seconded into the Action Zone. My work involved the development of a three-year health improvement programme across the ABI to identify local health needs and inequalities, to translate aims into measurable targets, and to establish monitoring and accountability arrangements with local partners. The impact of the changing role of the state, which had begun with the previous Conservative government and continued with New Labour's Third Way, positioned citizens as consumers, as discussed in Chapter 2. The Office of the Deputy Prime Minister introduced legislation including the NDC area-based initiative, wrote policies ostensibly to encourage citizen participation

within a whole-system approach and identified targets to improve the engagement of local stakeholders in decision-making and resource allocation. The resulting tensions are explored in the data analysis chapters, 6, 7 and 8.

It was whilst seconded into the HAZ that I began working, familiarising myself directly with central government and interfacing with the statutory and non-statutory sector providers to help implement these new regeneration policies designed to impact on health inequalities using participatory regeneration activities involving local actors.

My role as a development manager within the HAZ meant that, between 1998/9, one of my first responsibilities was to facilitate one of the five HAZ 'development sites', working collectively with four other HAZ colleagues. We were to facilitate and support the involvement and participation of the local community/voluntary groups, looking at specific priorities and action plans which considered the priorities from the inequality audit (HAP, 2000). The five regional HAZ health action project (HAP) development sites were identified because they were not currently being targeted, they had the capacity to change, had natural communities of about 10,000, and their health profile identified high levels of deprivation with failing services. It was at this point that I became involved in work as a development site manager in the research area-based initiative that later became the designated NDC site which is the location of this research. Working in the HAZ, I first met with all the key stakeholders and this early introduction to the actors in this area based initiative enabled me to have inside understanding of some of the dynamics and variables involved in the research (Figure 5.2).

Figure 5.2: Theoretical Framework



Source: F. Greenham, Complexity and Community Empowerment Presentation (2004)

In 1999/2000, on behalf of the HAZ, I was asked to begin working with the local authority partners on the bid for the ODPM Partnership £52 million grant.

At the same time, I established links with the Revans Institute in Salford University and began exploring reflective practice and action learning tecnics to examine whether these methods could be introduced to help the local actors critically question their changing health agenda.

5.3: Introduction to the disciplinary contours of the research

Implementing the NDC policy necessitated demonstrating partnership working with local people (ODPM, 2001: 14-15). The data collection analysis sought to identify whether the respondents' involvement in implementing the NDC health focus group programme did enrich and stimulate increased participatory, democratic discourse and help develop community governance models. My data collection and analysis involved questionnaires and in-depth interviews with the respondents, the analysis of the NDC and health focus group minutes and documents, contemporaneous notes of mine, the respondents' action learning reflective journals, published NDC reports, and

other relevant local and national documents from 1999-2010.

The epistemological assumption originates from the insider knowledge and understanding of the respondents as partners in the process, over the timeline, and from journals, minutes and in-depth questionnaires.

5.4: The central research question:

Has the introduction of New Labour's regeneration policy to increase joint working and participation in the NDC HFG resulted in a demonstrable increase in the communities' involvement in design, management and delivery of local health and well-being services, an increase of greater self-management strategies, or evidenced adoption of community governance models locally?

This research focuses on presenting the 'insider voice' of the local people and the front-line workers on their perceived levels of involvement and integration into the delivery of the NDC programme.

5.5: Theoretical framework for research

The NDC policy was developed as a means of devolving resources and allocating budgets to enhance community participatory democracy and place local citizens in charge of the redevelopment of their neighbourhood, working alongside the local statutory and non-statutory partners and actors (NDC DP, 2001: 4-7). The primary research strategy was to capture the data for analysis regarding the experiences of the respondents related to the new emerging spaces and their opinions on the devolved decision-making. The secondary research strategy was to capture data about the new NDC models that the health programme introduced, and the respondents' views on how they impacted on community participatory governance.

This research has an ethnography focus, and, as an insider social researcher, is founded on a phenomenological philosophy. Using reflective action learning research with individuals and collectives, the data was collected in order to explore the impact of policy on the levels of co-governance and participation in the NDC.

The NDC Board was the governance body directly involved in the development of the ten-year strategy outlined in the New Deal Initiative. The Health Focus Group and the Community Health Action Partnership, chaired by members of the local community,

developed the three-year health component of the NDC delivery plan. It centred on a community health action system, which included two facilities and a shared way of working across the health, social, private and voluntary sectors. The opinions of front-line workers and members of local communities, together with the levels of perceived empowerment, were documented and recorded as the NDC Health plan.

5.6: Intention, strategy and action

Giddens (2001) discusses 'an enabling approach' related to the Third Way New Labour's policies and suggested that, within the study of marginalised groups, the agency of the poor has often been denied. The efficacy of policy measures, he suggests, depends on how those targeted react to the policy measures and whether they actively participate in the process. He argues that the dynamic approach to on-going social reforms vindicated the poor, with claimants requiring active and dynamic policies (Giddens, 2001: 200-202). The research thesis involved analysis of the emerging, changing, NDC structures and agency and was inextricably linked with questions of power, causality, and political explanation. By opening up the process and including people in the decisions about the NDC programme health services, Stringer (2007) suggests that this extends their knowledge and mobilises the resources of the community. It opens the possibility of increased human resources and the formation of operational processes that are socially and culturally appropriate. Whilst the research sample was small they all adopted the action learning reflective approach which helped broaden the focus of the discussion within the wider health spaces and support the wider local actors to extend their knowledge (Stringer, 2007: 36). The analysis in Chapters 6, 7, and 8 explores this aspect further. Over the period 1998 to 2004, the longitudinal data collection continued to evolve as the NDC programme developed. Whilst I note that the research sample did not represent the views of actors who joined the area based initiative post 2000/1, they did however record views of the conflict and dissention that arose in the HFG and CHAP because of these new tactical actors imput.

The research examines and presents the '*insider voices*' of respondents who were either living or working in the area during the implementation of the NDC programme. Crowley and Hunter (2005: 265) suggested that evidence-based public health policy and practice had been driven towards a health service, performance management route. Crowley suggested that '*the public*' is a central focus within public health

practices, highlighting the need to integrate lay knowledge, increase reflexivity, and support the development of greater understanding about power, agency and social change (Crowley & Hunter, 2005: 267; McNiff & Whitehead, 2009: 124-126). Up to this time, the development of theory and research on health inequalities had inadequately addressed the relationship between agency and structure by omitting the significant contribution that local actors could contribute to rebalance this partnership (Popay & Williams, 1998a: 112). Engaging in a dialectical and recursive process is 'a *deliberate social process designed to help them learn more (and theorise) their practices, their knowledge of their practices, the social structures that shape and constrain their practices, and the social media in which their practices are expressed*' (Kemmis & McTaggart, 2000: 598).

As a social scientist, I was influenced by and acknowledge my feminist research design in the thesis, and suggest that emotional and social commitment is not inimical to scientific rationality, with detachment in the study neither feasible nor desirable: '*The collision between theory and praxis (abstracted reflection in practice) is as emotionally significant as it is intellectually interesting*' (Chisholm, 1990, cited in Robson, 1995: 65).

The research design sought to minimise any power differentials between the local actors. I adopted a flexible, participatory approach to help support a reflective environment within the NDC health and well-being programme, and to enable the process and emerging strategy to be controlled by all those involved. This was a deliberate, systematic process, introduced to respond to changing contexts and emergent findings as they arose (Ledwith, 2010: 93). The data collection was qualitative and conducted over a longitudinal timeframe, with the local actors and I being energetically engaged in an on-going dialectic and recursive interaction. The literature review has highlighted, from the perspective of those who formulated policies, a number of potentially unintended outcomes (Diamond & Liddle, 2005: 140). The environment was complex, with multiple actors changing positions and several research phases; commencing with the initial introduction of the NDC Pathfinder bid, followed by the award of the NDC, the formation of both the NDC board and the health focus group, leading on to the delivery of the NDC programme. The changing rhythms, multiple steps, multifaceted governance and the process of qualitative data collection were complex. The process of research collection and analysis has been described

as being as much '*art*' as science - with the '*dance*' of interpretation frequently changing (Miller & Crabtree,1999: 138).

Within my role of Health Development Manager working with local respondents, I acknowledged human agency, the social relationships and the social, political and economic constructs that were implicitly and explicitly connected with the NDC programme. In order to understand the respondents' position within the NDC programme, I sought to demonstrate and understand agency and structure in relation to the evolving and new political opportunities. Hay (1995: 192) argues that '*social or political structure only exists by virtue of the constraint on, or opportunities for, agency that it affects*'. To help understand the complex environment and how to best promote public health change, I adopted an '*action research'* approach which involves a spiral of cycles of planning, acting, observing and reflecting (Robson, 1995: 438).

The NDC programme implementation and the research strategy which both started in 1998 evolved intuitively, and I used journals and reflective discussions to clarify the different issues and concerns at this early stage of the programme. With time, the main focus of the research thesis shifted and was reconceptualised with a growing understanding of the interactions between the Third Way regeneration policies and the NDC programme (Chapters 2, 3 and 4). My questionnaire to the purposeful sample of operational, tactical and strategic respondents sort to capture their views and reflections on the changes to participation and involvement over time (Appendix 2). The changing landscapes of the health and welfare structures caused by the policy changes have been discussed in Chapters 3 and 4. Another change was that the previous community development metric was being replaced by social capital theory, which took precedence with the introduction of the Third Way.

5.7: The methodological perspective

Action learning research is a transformative process (Ledwith, 2010: 220-221) whereby individuals try out new ways of doing things related to behaviours, processes and systems relevant to a specific issue or project. Researchers make observations on events, reflect on those observations, learn from their reflections, and make modifications based upon what they have learnt in a cycle of self-improvement and continued professional development. It is a continuous and intentional process of learning and change from actions taken (Stringer, 2007: 147-151; Revans, 1966).

5.8: Action learning, reflective practice

Action learning was chosen as my research strategy as it involves a spiral of cycles involving planning, acting, observing and reflecting (Appendix 1) with the emphasis on a specific situation that particularly suited the stages of development of the CHAP and HFG health and well-being programmes (Robson, 1993: 438-440). Action research was first identified in the 1920s (Lewin, 1946), then re-emerged within the educational arena in the 1940s (Kemmis, 2000). Lewin (1890-1947) was a psychologist of the Gestalt school who became interested in concepts of social behaviour and change. His original view was that raising the self-esteem of participants is a goal of action research. Lewin's theoretical framework was based on social and experimental psychology, while Kemmis (2000) was concerned with psychoanalysis and social psychology.

In 2002, I successfully completed an application for an NDC funding grant. This enabled up to 28 of the NDC health focus group members to be able to access training from Revan's Institute in action learning tactics and to learn how they could widen the use of reflection within the wider community. Up to 28 actors involved in the NDC HFG subsequently became affiliated to the action learning sets and were offered the opportunity to enrol at the university to undertake accredited programmes (Revans Institute, 2002). Eight of these local actors then went on to become part of the purposeful sample which contributed a primary data source and completed semi-structured interviews in 2007/8.

5.9: Ethical considerations and action learning

The aim of this qualitative research was to elicit the operational, tactical and strategic views of the local actors' involvement in implementing the NDC policy along the extended longitudinal timeframe. The study began in 1999, making it almost a 20-year journey and raised ethical complexities and challenges which were magnified due to my dual role of working closely, over an extended period with the local actors. My major concerns were around consent and preserving the anonymity of the respondents whilst maintaining confidentiality and protecting the participant's privacy. As the researcher, the ethical considerations also included managing what happened to the data, the impact of the research and the on-going repeated involvement that may influence and shape lives of the respondents over a long period of time. I

acknowledged these ethical considerations and of my dual position as somebody investigating and delivering the NDC health policy. As a social scientist, I was involved within the NDC programme every day; my observations were a continuous iterative process and the creation of the data and delivery of the NDC programme was part of the dialectic (Guba, 1981: 204-206). As this on-going dialectic took place over an extended longitudinal period, I was particularly conscious that my observations and understanding grew as my relationships developed. Additionally, new actors who brought different perspectives, came into the area-based initiative after the NDC had begun its 10 year implementation programme. To facilitate a supportive, participatory involvement from the local actors, I needed to put myself in their shoes, be cogent, honest and ethical. I worked as a social scientist and a Health Development Manager from the conscious perspective of acknowledging that I would behave with the local respondents in a way that I would want to be treated. This also meant that, in understanding or uncovering data, I was bound to ensure the local respondents' consideration and privacy, and gain their informed consent, not as a one-off event, but consciously consulting with the respondent as necessary throughout all phases of the research including data collection, analysis and final reporting (Guba, 1981: 210). The process of developing relationships and entering ethical relational networks was incorporated into the dynamic methods used to establish the NDC focus groups in 1999/2000. I was conscious of this when using the secondary data analysis with minutes and journals sometimes recorded after the events. I had specifically chosen participatory action research using observation and an analysis of the contemporaneous minutes and notes in recorded forms as part of the data source. My mixed methods approach to data collection also used the respondents' recorded observations from their action learning sets which helped to generate increased intro-observer reliability (Robson, 1993: 221). As the focus of the research specifically interrogates the longitudinal participatory involvement of the local actors, the data collection tool was imperative to ensure that all the participants knew what was going on and that the processes were inherently transparent to all (Stringer, 2007: 55). Within this research study I concentrated on a small sample of respondents who were involved throughout the whole of the timeframe, however I acknowledge ethically the differing views of the actors who joined the ABI post inception of the Pathfinder status may offer a different perspective. Further research exploring a sample of dissenters

and actors who came into the ABI later could add and possibly strengthen the research findings. A wider sample would also meter against any possible researchers biased.

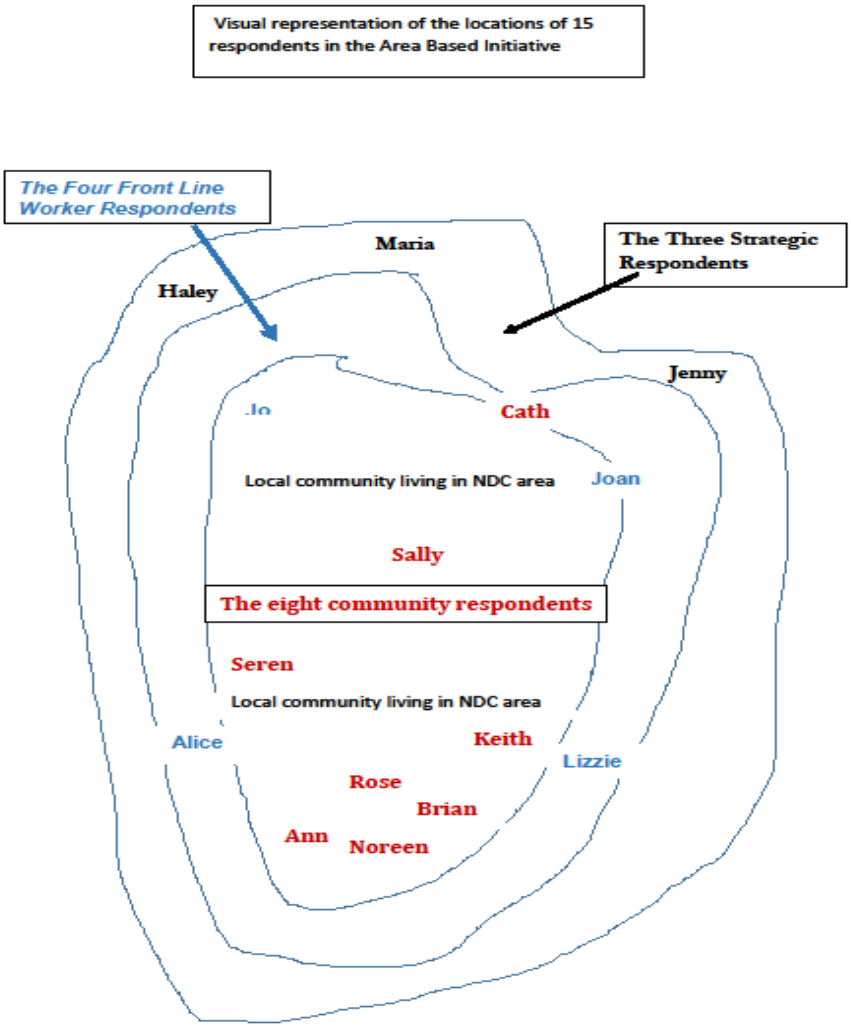
Action learning helped facilitate those involved in the process to gain an insight into the activity and support the production of change in that context, as action learning requires collaboration between the researchers and the practitioners. Within the delivery of the NDC programme, practitioner participation in the delivery process is central, as it is in the action learning research process (Stringer, 2007: 20-24; Ledwith, 2010: 211-12). The intended effects of participating in an action learning set are to contribute to scientific knowledge, develop identity in individuals, and support reflective behaviour within organisations and social change (Revan, 1966; Stringer, 2007; McNiff, 2009).

I was involved in my own action learning set from 2000/2001, and I introduced this practice as an opportunity to use, as Gaventa called them, '*the invited spaces*' (Gaventa, 2004: 4) as a place for the HFG/CHAP actors to reflect on their work together. The HFG and CHAP members adopted a way of working together in these collective spaces to search for solutions to issues and problems. The principles of action learning research (ALR), with its cyclical questioning and reflective enquiry, helped the set members develop a way of trusting, listening and reflecting whilst designing the NDC delivery plan. During these meetings, the individual participants within the groups asked questions and, after discussion, came to a consensus on actions. With established behaviours, the members of the ALR groups helped each other evoke reflection, presenting what they wanted to do and problems that had arisen and after discussion, the agreed upon subsequent actions were classified and written into the delivery of the NDC health programme. This way of working helped accommodate the potential health and welfare changes they wanted in the NDC area, strengthened partnerships and increased the participation of local citizens.

This research is grounded in emancipatory enquiry, challenging the inequalities and injustices that affect health in society. The data explored the process, investigating the inter-subjective praxis where efficacy and subsequent collective action occur (Ledwith, 1997: 95-97), and I acknowledge the sensitive issues arising from the dualism of the macro- and micro-elements researched. I acknowledge from my feminist stance the ethical considerations in my dual role as the worker/researcher and as an enabler.

When I was employed as Health Development Manager, I acknowledged that my role as 'a practitioner researcher' could be construed as contentious. Throughout the research process, I understood and observed protocol, and consulted and gained explicitly any necessary permission to share data. My involvement with the 15 local respondents and wider actors has maintained explicit authorisation with transcripts, attributed observations and recorded minutes.

Figure 5.3: Diagrammatic representation of the regeneration partnership area and location of the 15 respondents



I obtained signed consent prior to conducting the 15 taped semi-structured interviews and returned a transcript of the tapes for approval and amendment to each of the respondents. I have anonymised the data throughout the thesis, including that which would form part of the meta-data and micro-data analysis. In 2004, my line management changed and my role as Health Development Manager within the NDC was suspended by the incoming PCT Chief Executive. This substantial change in my role in the fourth year of the ten-year study shifted the ethical perspective within the research, as from 2004 to 2007 my involvement in the area-based initiative was solely as a researcher without the duality of role.

When developing the research strategy in early 2000, I consulted and sought both permission and approval from the university ethics committee and from the primary care teaching and learning ethical committee. I submitted a full request for ethical approval, outlining the design of the enquiry, informing them about the involvement of the participants and my understanding of and responsibility for maintaining confidentiality, and I obtained explicit authorisation prior to commencing the research study. The ethical approval application (Appendix 2) explicitly outlines the involvement of local respondents and the use of the action learning participatory process (Revans Institute, 2002). I openly recognised my ethical position as inside the domain of the study, as the Health Development Manager employed by PCT/LA for the first four years of the research until 2004 (Robson, 1993: 33-34). As the resource person, I was the catalyst helping to enable people to work from '*where they were'* and analyse the process (Stringer, 2007: 24-25).

5.10: Participatory joint working across HFG/CHAP

It was from 2000/1 to 2004, as the inside researcher, that I worked collaboratively to support and facilitate the local actors in the enquiring process using Revans' learning principles (Revans, 2017). Following these principles helped me to engage with all key stakeholders and ensure that the end results integrated their perspective and priorities (Stringer, 2007: 115). For example, to help the local actors facilitate and formulate the HFG plans based on their own interpretive lens, we used Revans' learning principles in, 2003 to understand the complex public health facts related to the area-based initiative and the health indices. Initially, I collected the public health information for the two ABI adjoining wards and, together with the chair of the CHAP group, we organised meetings and discussed this information with the HFG/CHAP members. This reflective questioning and these open discussions informed them about the prevalence of ill health and the patterns of illness as they occurred in their geographical area. They questioned and discussed the '*real world'* relevance of the information; speaking to each other, they used the process of the meetings to discuss the issues and together developed their evolving first drafts. The community needs assessment was designed and developed using the open spaces for local actors assessing the agenda, reviewing the descriptive information and distilling together what, in this instance, was the existing health data, to ensure that the local voices of the front-line people were heard in the planning (Stringer, 2007: 117-119). This new format of working together,

adopting the action learning sets principles, evolved and became established as a way of approaching the development of the health focus group regeneration programme. It was in April 2001 that a group of over 40 local people – front-line workers and senior managers – spent the day working together, reinterpreting their health needs assessment into a health strategy. By 2001, the HFG/CHAP were strong established groups which complied with the central government policy of front-line workers and local communities working together using action learning set principles and co-production to redesign health services. Using the action learning reflective set principles, the local respondents discussed how they wanted to address some of the ABI preventative health services. The HFG introduced programmes of self-management for people with chronic long-term conditions with peer to peer training to enable local citizens to stay as well as they could for as long as they could (NDC AHR, 2002).

5.11: Participatory involvement of the community

In 2001, the Partnership Board agreed to and commissioned four people from the local community to be employed from the NDC resources as '*community animators'*. These community animators were introduced to support and strengthen interactive, participatory exchanges between the residents, to ensure accurate representation of the area-based populations' views and support their views being translated into the NDC delivery plan. Two of these community animators became part of the 15 local respondents whose views and data are analysed in this thesis.

5.12: Rationale for data collection

Data collection on Wassail and Boothtown New Deal for Communities regeneration programme (NDC, 2001: 28) occurred over a ten-year timeline between 2001 and 2011. Data collected from members of the New Deal for Communities urban regeneration partnership, and additional sample data derived from documentation related to that programme, were collated (Appendix 2). By introducing action learning research opportunities to front-line workers and community members, it helped encourage the participants, starting with their experiences, to understand what was going on, working together and acting as the central stakeholders, and sharing reflective diaries (Ledwith, 2010: 186). The data originated from members of the local and national government, the Primary Care Trust and expert informants, in addition to the front-line workers and local people.

5.13: The stages of the research

5.13.1: Establishing the learning environment

The local actors needed support to engage in the process of developing and implementing the NDC policies. This stage involved the formation of the health focus group/community health action partnership in 2000; however, prior to the formation of the collective groups, the individuals first needed to get to know each other. It necessitated identifying and defining the organisations involved and all the key stakeholders. To establish trust, this stage also involved ensuring the HFG/CHAP had a safe participatory space and an opportunity to agree on the action learning model. Finally, the local actors began to clarify their roles and responsibilities within the HFG/CHAP.

5.13.2: Mapping the health environment: identification of health priorities

The local actors identified the community/clinical partnerships, selecting and agreeing the health topics and projects that were important to them. Working together, they undertook an NDC area public health/community needs assessment. This helped the group to reflect on and verify the agreed health projects they wanted to put into the NDC health plan. Organisational and individual skills and competencies were identified within this stage.

5.13.3: Moving to action

The formulation and agreement on the individual health projects moved the HFG/CHAP towards action, which entailed agreeing and developing models of community governance. The discussion and sign off on the health projects and resourcing and management models were taken outside of the HFG/CHAP forum at this stage for approval by the NDC Partnership board.

5.13.4: Delivery of participatory health and well-being projects

A variety of partnership health projects were implemented by HFG/CHAP involving local residents, PCT and local authority, public sector providers, community and voluntary organisations, and businesses working together. The 19 action learning set projects supported the process, management, and delivery of these new complex participatory health and well-being interventions.

These health project deliveries involved the NDC action learning sets framework working together in teams across clinicians and communities sharing integrated learning between 2000 and 2004. In 2002/3, this involved 19 individual health projects being delivered in clusters, in partnership with local clinicians and local people. The data was collected within the NDC partnership board, which documented these new models involving community governance. In the minutes of the meetings and in their journals, the local actors recorded their thoughts related to the on-going spiral process of their involvement in the planning, action, observation and reflection. It was their insights and perceptions of involvement and participation in NDC health delivery that was captured by the research data.

Table 5.1: Chronology of NDC policy implementation: data collection

When	What	How
1998/99	Within both the wider city and area based geographical area, gathered opinions and direction from a wide range of partners including the community; formed and developed the Partnership bid.	Open Space events Individual and focus group activities Snowballing
1999/2000	After consultation within the community, the formation of the initial key members of the NDC HFG emerged, and the main features of the NDC health plan were identified.	Discussions / debates Meeting minutes Data recording and refining
2000	The NDC partnership bid was successful and central government invited the city and Wassail and Boothtown to identify a ten-year delivery plan.	Meeting minutes NDC grant awarded with targets Public health documents
2000/1	The NDC delivery plan was identified. The governance infrastructure of the NDC was agreed upon, and the membership structure of the NDC Partnership board and the HFG membership was ratified.	10-year NDC Plan published involving all voluntary statutory third sector local community and front-line actors. Community animators
2000/1	The membership of the NDC health focus group of front-line people and clinicians and the membership of the community health action partnership were identified. Both the HFG and CHAP groups introduced action learning research (ALR) and collected data that is analysed within this thesis. ALR	Self-selection community representation, Community animators professional-led representation Local actors explored praxis model ALR

When	What	How
	was used to help the local actors identify the barriers and solutions, and participate within the NDC programme. For the pathways for involvement in the NDC HFG, see Fig. 5.2.	guided by Revans Institute Invitation to local actors to form smaller ALR sets
2001/2	The citywide health and welfare provider services' infrastructures were reconfigured. This included the development of the Primary Care Trust (PCT) from the previously existing Community Trust; the local authority developed local strategic partnership structures.	Central legislation / policy directives
2006/7	Data collection involving 15 local community members, front-line workers, and senior strategic managers (Appendix 2).	Semi-structured questionnaire

By 2000/2001, I had intentionally involved the respondents in documenting and discussing their actions, issues and concerns related to development of the health programme. I facilitated and encouraged participatory reflective-action working groups to discuss, question, and understand the factors influencing the roll-out of the programme. The respondents quickly began to define and debate the actions and priorities of the health focus group and the community health partnership. The new spaces that evolved allowed the HFG/CHAP and residents to begin focusing on eliciting narratives about understanding their roles and how to participate in the programme.

5.14: Insider Researcher - Development of HFG and CHAP

My role with HAZ gave me the opportunity to work with the local authority, voluntary sector, religious-based organisations, health providers, and the local community to develop the partnership board and the new infrastructures necessary to deliver the NDC programme. It also gave me an opportunity as insider researcher to reflect on changes, to collect the data that arose from the contemporaneous notes, minutes, and action learning sets, and to negotiate with a small purposeful sample of front-line workers, local people and strategic respondents who consented to be part of the on-going research (Appendix 2). The area based initiative was introduced with the intention of supporting the development of a real-world solution with local actors designing and testing new interventions and services. This would then help set out a new strategic 10-year framework for the regeneration of the area. The action research design was chosen as it is concerned with solving concrete problems and developing real solutions where the enquirer works inside a natural setting (Robson, 1995: 61). After the NDC grant was awarded I took on the role of facilitating the NDC Health Focus Group (HFG) on behalf of the HAZ/LA/PCT. This insider - outsider position involved building trust and agreeing to boundaries around confidentiality, undertaking a variety of activities including recording and documenting events in the NDC focus groups and supporting individual and collectives to maximise their ability to participate, as they wanted to, in the design and development of the HFG delivery plan.

At the NDC programme launch in March 2000, local people who wanted to be involved in the planning of the new health services started identifying themselves. Six months later, they were meeting on a regular basis, analysing data, shaping the plan, and

forming themselves into the community health action partnership (CHAP). Most of this group had not been involved with statutory agencies in a formal way before. They became a constituted group in October 2001, successfully conducted their first annual general meeting, and began managing budgets which involved delivering the real-time community change projects – the sugar-free group as well as food cooperatives. In October 2002, CHAP became an incorporated company, with plans to manage/employ the NDC health staff using area regeneration funds.

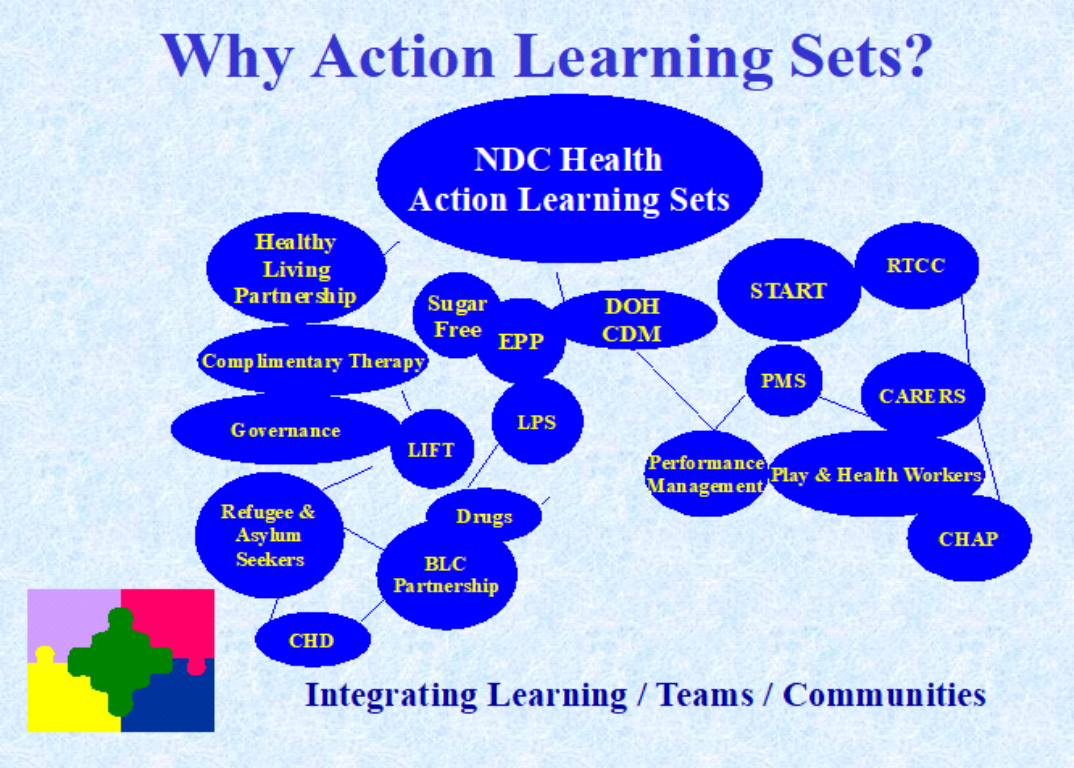
CHAP identified their aims and objectives as follows:

- To empower local people to work together with key professionals and managers to regenerate existing health and social care provision in Wassail and Boothtown; and
- To develop new and sustainable systems for enhancing individual health and well-being alongside the development of the community (NDC AHR, 2002).

As the Health Development Manager within a complex longitudinal programme with my dual role of researcher, my own ALS allowed me to adopt protective time for reflective practice. Joining my own action learning set at the Revans Institute allowed the development of an impartial confidential space to meet regularly with others and share reflection on our current working practices.

The development of the NDC action learning sets (Figure 5.4) illustrates the evolving pathway that the key health focus group stakeholders followed as they engaged with the regeneration programme and established the health and well-being plan that they eventually submitted to the NDC partnership board.

Figure 5.4: The Action Learning Sets



Source: Greenham (2004)

In 2001, I moved out of the HAZ and took the first joint-funded post between the Primary Care Trust, Public Health Directorate and Local Authority New Deal for Communities as a Health Development Manager. This position gave me continued access and support for this research work, as the CEO of the HAZ moved into the CEO role within the City PCT at the same time, and condoned and understood that the parameters of my work were to encourage participatory involvement of the local community. My responsibilities included chairing the Health Focus Group, and I became a member of the Salford Health Information Finance Trust service redesign group, which gave me wider access to the research field of study. As referred to earlier, in 2002, I submitted a successful bid to fund an opportunity for a local University to facilitate those NDC HFG participants who wanted to access one of three action learning sets (NDC, 2002). My final data collection occurred in 2007-2008 when I collected the questionnaire transcripts from a purposeful sample of 15 local respondents. The thesis was informed by this primary data source of 15 semi-structured interviews and questionnaires, and from the rich secondary data collected

from my action learning reflection notes and the NDC/HFG contemporaneous notes and minutes.

5.15: Data collection stages

The research data collection began in 1999/2000 and it involved many different phases of planning and engagement with local actors to identify the most acceptable ways to develop effective participatory approaches. As the HAZ work developed, I explored how to ensure the local community's engagement in jointly helping to identify and build the mainstream health and well-being agenda for the delivery of the HFG NDC programme. I continued to facilitate the process to ensure safe community spaces and continued establishing trust to support the development from the beginning of effective equal partnerships with local people and front-line workers.

5.16: The data collection instruments

My data collection tools used mixed methods, including participant observation and semi-structured interviews. In the first phase of the implementation of the NDC policy, I introduced the concepts and frameworks of reflective practice action learning sets to the local actors as I felt they encouraged the fostering of close enquiring relationships with the respondents, identifying problems and solutions through participation in the delivery of the NDC HFG programme from 2000 to 2004. The observation and the data from the local respondents, as well as my own action learning sets journal notes, formed part of the initial research data collection tools. The additional observations, interpretation of contemporaneous notes and minutes, and published documents from the NDC also contributed to the data analysis. In 2006/7, a purposeful sample of local front-line workers and community members was selected to specifically analyse their involvement and participation in delivering the NDC health programme. From the initial sample collected, I extended my interviews with the rationale of ensuring I included a strategic perspective in the final analysis.

5.17: Design considerations for the semi-structured questionnaire

After leaving my full-time employment within the LA/PCT in 2004, I continued my relationship with the local actors as a researcher based in the city University. In 2007, I enrolled at Bradford University and began the systematic scrutiny of the secondary data from my journals, the NDC participant testimonials, reports, minutes, and other

contemporaneous data captured across the longitudinal timeline from 1999 to 2004 in order to elicit meaning about why and how the local actors had participated in the delivery of the NDC policy and the impact of the centralist legislation. In 2007, I decided to undertake a further data collection from a purposeful sample of local respondents to understand retrospectively the local actor's views. I chose semi-structured, face-to-face interviews to enhance and emphasise the individual voice of the respondents, collecting views which focused on the characteristics of each individual and their attitudes and beliefs about '*when, why, what*' happened when you participate in the area-based initiative, with concluding prompts about the belief in what they felt they had achieved or would change (Appendix 2).

My thesis used a qualitative approach to capture the views and the social reality within the localised setting of the ABI. Data collection methods of semi-structured interviews with the 15 respondents captured the reasons why they got involved, how they had participated in the NDC programme, how this participation had affected them, and the dynamics of the specific health area that they were involved in. Whilst identifying the most appropriate questions best suited to answer the thesis' enquiries, I acknowledged the complex well-being environment and the multiple factors that impacted on the community's ability to participate in implementing the NDC policy.

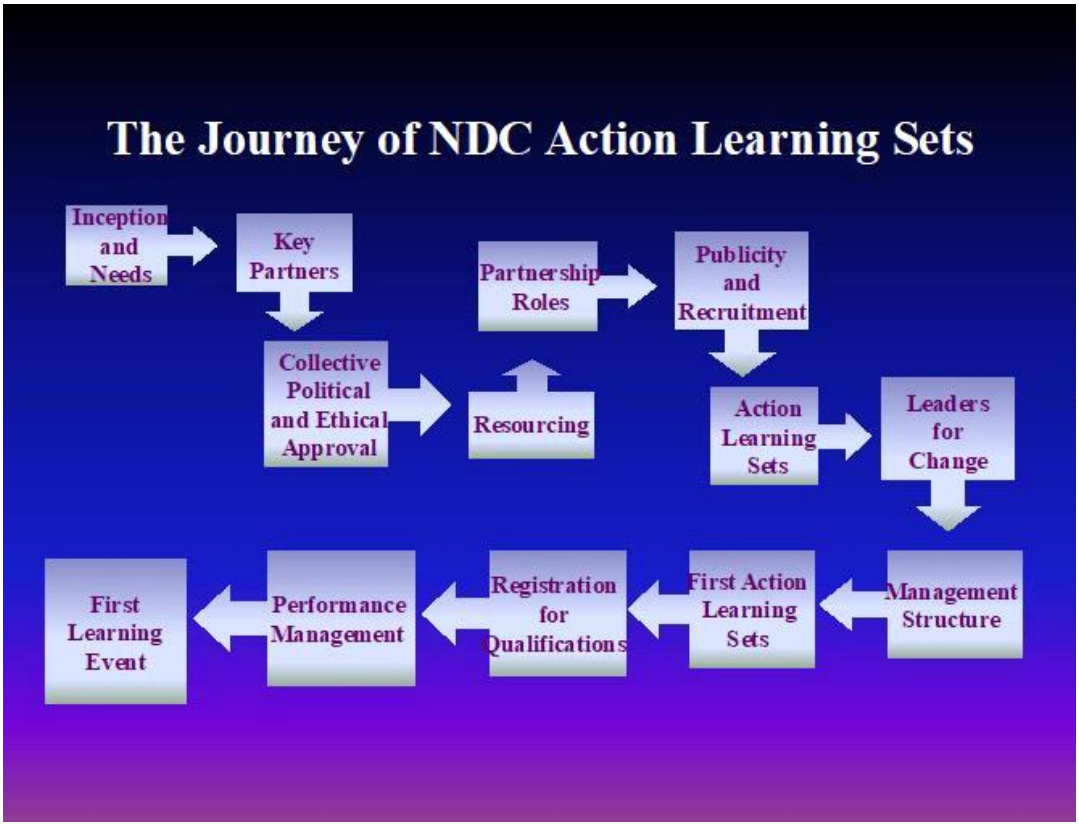
'*One of the ideas arising from complexity theory suggests that the health service is a complex adaptive system – it does not behave like a very large but essentially predictable machine but more like a complex living organism. Arguably, the approach to the management of change in the NHS has assumed a rational–linear approach, rather than approaches that recognise the complex nature of the organisation. An example of how the health service behaves differently as a 'living' system rather than a machine is in the non-linearity of input – response effects. With complex systems small changes can give rise to big effects. If this is true it opens up exciting new possibilities for how we can understand and manage health policy and health services.'* (Zimmerman et al, 1998: 8-9)

5.17.1: Action Learning Sets

By 2004, both HFG and CHAP had evolved and developed a systematic approach to establishing the process of how the front-line staff, local people, and communities

worked together using the action learning sets. In the action learning set spaces, they had agreed and were documenting the process of working together and by 2004 there were 19 action learning sets delivering on individual health strands in the NDC HFG supporting integrated learning (see Figure 5.5). The rich data transcripts of the purposeful sample of 15 respondents who undertook the semi-structured interviews, their experiences of involvement within the health focus group work, and the research findings are explored further in Chapters 6, 7 and 8.

Figure 5.5: The Journey of NDC Action Learning Sets



Source: Greenham (2004)

5.18: The research focus groups

The original cohort of people who contributed to the research data were from the NDC Health Focus Group (HFG) membership and the Community Health Action Partnership (CHAP). This collective agreed to work together in a focus group to enable in-depth, reflective practice to develop a critical praxis for action (Ledwith, 1997: 98). Their findings then informed the emergent, health-planning process inside the NDC. From within this group, a smaller focus group of action learners agreed to reflect and

record their on-going work within the HFG over a longer period of time. It was these respondents that then became affiliated to the local university's Health Action Learning department for academic support from the local University Revans Institute in 2002.

5.19: Summary

The research strategy was chosen as it allowed the exploration of the spaces for participation and involvement of the front-line workers and local people, over the longitudinal timeframe. The mixed methods of observation and semi-structured interviews examined the development of and the participatory involvement of local actors in the new spaces that the NDC policy afforded. The analysis of local respondent's views on how, why and what they participated; characteristics of collective action and the catalysis for sustained change are presented in Chapters 6, 7 and 8.

6: Participation in the NDC - Wassail and Boothtown: An analysis of the workforce views

6.1: Structure of the data analysis

The format and structure of the next three chapters are similar; they contain the data-analysis from the front-line workers, the community respondents and the strategic managers respectively. The key data analysed is the fifteen respondents' transcripts, however, I also draw on journal notes, minutes and published documents to validate and triangulate the findings, where appropriate. The thesis identifies the key, joint themes that emerged from the fifteen respondents' transcripts related to their views and collective experiences of the new opportunities and participatory spaces that the NDC programme opened up. The sample is purposefully stratified to enable operational, tactical and strategic perspectives to emerge along the longitudinal timeline.

The next three chapters are based on the respondents' experiences between 1999 and 2007. The research findings identify patterns and relationships within the regeneration programme setting using a thematic approach to analyse the data detailed in appendix 1. They initially introduce key characteristics and show why the respondents were involved from an emic focus. The concluding part of the analysis documents the key themes, lays out the respondents' view on the achievements and outcomes within the NDC programme, and identifies the barriers and issues that arose when implementing the new participatory structures.

The iterative, reflective process began in 1999 when I was involved in establishing the area-based, regeneration programme. Consciously, from an etic focus, within the analysis, I attempted to distinguish meaning to elicit the interrelated themes whilst progressively refocusing the data analysis into the core, emergent findings related to the respondents' experience of that participation and involvement. From an etic focus, as the insider researcher and key informant, I use participatory observation to also consciously inform the data findings. My inductive analysis interrogated the values that have influenced the research and acknowledged the critical paradigm that unfolded over the ten-year timeframe of NDC policy implementation. It also acknowledges the impact of the new wider policies and legislation that the central government introduced, particularly the Treasury department's public-private financial policies.

The respondents' experiences and views are expressed in the text and in their quotes drawn from the interview transcripts. All the experiences described in the data-analysis chapters took place against the context of the national government's introduction of the NDC regeneration programme and the particular emphasis within government policy on increasing community participation and involvement, and enhancing democratic community infrastructure within the local populations who were experiencing the regeneration programme.

This first data analysis (Chapter 6) is based on a series of interviews with four of the front-line workers working within the statutory and voluntary sector in Wassail and Boothtown when the Pathfinder status and the NDC programme was first awarded.

The chapter includes:

- My role;
- The characteristics of the respondents;
- Why the respondents participated in the NDC programme;
- The respondents' experiences of the new structures for participation arising during the NDC;
- The partnerships and opportunities;
- The achievements and the barriers; and a
- Conclusion.

6.2: My role

This data was collected from 1999–2007 using the context of my role as a Health Development Manager and as the insider researcher. Using the ethnographic research methodology described in Chapter 5, my research involves self-observation and reflexive investigation in the context of my employed role within the NDC. In 1999, I was responsible for supporting the local community to directly become involved and participate in the NDC programme. This was initially from my position in the HAZ and then in my joint LA/PCT role. My two-year work objectives, agreed jointly by the Chief Executive of the HAZ, Chief Executive of the Local Authority NDC and the Director of Public Health PCT, stated that I adopt:

- '*a plural approach, working both with the Local Authority and PCT at the city level and also within the NDC regeneration programme'* (FJG, Objectives,

2002),

My objectives included that I was to pilot new health models that demonstrated a new community empowerment approach. Specifically, Objective 4 stated:

- *4) 'To show evidence of a plural approach and joint performance management. To undertake joint reporting and feedback mechanisms which incorporate all partners (LA NDC PCT) by producing a pilot framework model. To demonstrate key stages throughout the health development work;*

(a) Design and draft a performance management model for approval.

(b) Introduce a chronic disease community management model, (which demonstrates) community empowerment and health gain.

(c) Demonstrate consensus with all Key stakeholders to approve a new health facility.

(d) Pilot and modify the new models ensuring links to PCT/LA targets.

(e) Approval to be gained submitting an NDC appraisal form for health resources x 2 years. Timeframe October 2002 to January 2003'.

(Greenham, LA/PCT Health Development Manager - Objectives, 2002–2004)

It was by introducing and using the praxis change model (Figure 5.1) that I was involved in building a base for capacity building within the NDC, which could facilitate a greater leverage for the local actor's greater leverage to harness control and decision-making power both for themselves and the wider community. The praxis model allowed me to coordinate reflective spaces within the regeneration programme, with permission, for the local actors to develop community governance models using the centralist participatory policies in the NDC legislation. My detailed objectives enabled me, as a Health Development Manager and inside participant observer, to experience the changes first-hand across the evolving, longitudinal timeline and note how the community responded. My joint LA/PCT health-development role provided unique opportunities, as a worker inside the NDC, to observe the emerging group dynamics and to understand what factors contributed to support, and helped to maximise community involvement. As a Health Development Manager, I reported to the senior management within the LA, PCT and the NDC frameworks. I worked directly with the strategic respondents developing the new, participatory pathways and their views and perspectives are analysed in Chapter 8.

As the NDC Health Development Manager, I had responsibility for working with both

front-line workers and the local community. This role gave me permission to work with the operational, tactical and strategic actors delivering the NDC health programme. I experienced working with the operational actors at the horizontal axis of the emerging programme. In my role of communicating and updating the strategic and senior managers, I also had first-hand experience of the multi-layer governance, the new public health agenda involving local actors' work and both the horizontal and vertical axis that the regeneration policy had introduced. This is discussed in Chapter 3 (Chapter 3: Figure 3.2. vertical and horizontal governance). The research involved operating across the vertical and horizontal axes and I encountered a rich, first-hand experience over the first five years of the NDC programme with the differing personalities, dynamics and cultures.

6.3: My role as an insider researcher and employee in the NDC

Within the NDC programme, I had two different roles between 1998 and 2004. Initially, I was seconded into the Health Action Zone (HAZ) in Manchester, Salford and Trafford from the Liverpool Health Authority where I had been a joint commissioning manager. For the first two and half years of the research, my direct involvement in the NDC regeneration programme was as a Development Manager in the HAZ facilitating the work to enable the bid for the Pathfinder status to be submitted to the New Labour Office of the Deputy Prime Minister. In 2000, as my HAZ Chief Executive relocated into the PCT, I took up one of the first, jointly funded posts between the newly formed Public Health Department in the Primary Care Trust and Local Authority City Council Chief Executive's Department. These roles afforded a unique opportunity to work directly and closely with all the local actors and community respondents throughout 1998 – 2004. Across the longitudinal timeframe of this work, I continuously kept journals and recorded my observations. My journal notes and reflective observations helped me shape and progressively reinterpret meaning as the NDC events and activities unfolded and to analyse the respondents' data as part of this integrative process.

Both roles afforded a unique opportunity to work very closely with the front-line workforce and also the tactical and strategic managers inside the systems. The local actors had a formal right to participate in the process of delivering the programme and my data for analysis emerged from multiple sources. This included the joint HFG and CHAP participatory spaces that emerged, and the purposeful questionnaires. Gaventa

suggests it is critical to understand how and in whose interests these participatory spaces were created, and the power dynamic, as '*those who create a system are more likely to have power within it and those who have power in one, may not have so much in another* '(Gaventa, 2006b: 26-27).

As a social scientist, I had to think systematically about how best to frame the complex contexts of the research, in order to effectively engage with the local residents and front-line workers over the longitudinal time framework. Framing the research engagement goals and identifying the relationships inside the initiative using reflective practice and my notes helped me progressively interpret and refocus the development of the programme activities and substantially add meaning by examining what was happening. These journal notes and reflective observations also helped me shape and progressively reinterpret meaning as the NDC events and activities unfolded. Millar and Crabtree (1999) describes the complexity involved in piecing together the research methods with strategies and understanding how these fit into the analysis as a '*dance of interpretation*' (Millar & Crabtree.1999: 127) As the qualitative researcher, I had to decide and make sense of how the '*dancers*' or the '*respondents*' related to each other. The process of implementing the NDC health policy was like the dance, and to make sense of the information I had to keep re-describing and re-adjusting the analysis with the various partner's data, acknowledging the complexity, changing pace and actors and the multiple data sources and that '*once at the dance the music often changes and new partners appear'* (Millar & Crabtree, 1999: 129). It was using these insights and the '*dance of qualitative analysis'* that I analysed the respondents' data as part of this integrative process (Crabtree, 1999: 127-129).

6.4: Key characteristics of the four front-line workforce respondents

The participants within the NDC programme came from a variety of different health and social-care backgrounds, including church members such as lay preachers and ministers, youth and social care workers, mental health support workers, teachers and educational support workers and more. I chose to interview these specific four respondents as they represented four distinctly different workforce perspectives. All of the respondents had been involved from the inception of the programme and they also helped design and deliver the health focus group (HFG) work streams.

Table 6.1: Workforce Respondents

The Four Workforce Respondents		
1. Joan	Health Visitor delivering clinical health services directly to children and parents.	Joan was in her early 50s, a clinical practitioner for over 27 years, with experience of the changes in the NHS delivery. She had experienced the direct impact on local people caused by deprivation in the area and services closing. In 1996, whilst working as a Health Visitor in Wassail and Boothtown, the clinic had closed and moved to the neighbouring area. She identified the ABI as poorly served by community health services with no local baby clinic, and only 2 part-time single-handed GP practitioners operating in the area. The transport links to better served neighbouring areas were inadequate. She became involved in NDC in 1999.
2. Alice	A local authority worker seconded to support and develop the new Pathfinder status. From 2006 onward the NDC Deputy Chief Executive	In her early 30s with a young family, Alice commuted daily from Cheshire. She had worked within the local city council for five years in various different departments prior to New Labour coming into government, and was involved from the very beginning with helping develop the business case to secure the first stage of the Pathfinder's status. Alice was promoted in 1999 to NDC manager facilitating the off-site team and the NDC Partnership Board. Alice had a unique insight into the changes introduced by the NDC policy throughout the whole 11 years life of the regeneration project.

3. Jo	An Expert Patient Health Trainer working with adults with long-term limiting health conditions.	Jo was in her late 20s, educated at Manchester University in Psychology, and had lived with progressive Still's disease or rheumatoid arthritis since she was a child. A determined and intelligent young woman, she had first-hand insight into the acute and chronic health services in Wassail and Boothtown. When she first became involved in 2000 in New Deal for Communities, initially in a voluntary capacity, it was because she had failed to secure employment or been shortlisted for interview. She worked part-time as a Health Trainer and also looking at the participatory governance arrangements within a number of the Wassail and Boothtown health services. A third of the population were documented as living with a long-term condition. Jo supported the development of active partnerships between patients and service providers.
4. Lizzie	A Community Development Worker facilitating regional involvement of local people.	The Community Development Worker, Lizzie, lived in the neighbouring city and was seconded by the Health Action Zone in 1999 to develop three pilot projects and development of Local Area Groups to inform the HImPs. A woman in her early 30s, Lizzie worked inside the community as the New Labour policies were introduced and piloted and had responsibility to embed the new community participation models.

6.5: Why these respondents got involved and participated in NDC

All four respondents' data demonstrated they understood that the purpose of the New Labour regeneration policy was to focus on a specific geographical area experiencing health inequalities and to work with all the actors, including the local community, over a ten-year period to develop plans in partnership. Half of the respondents lived in the geographical area that the regeneration programme was being delivered in and wanted the opportunity of working both with individuals directly and within collectives to improve the population's health status. All respondents welcomed the opportunity to be involved in the NDC programme and all were aware of a need to do things differently and wanted to develop models of delivery with local people. The respondents also repeatedly mentioned that, when implementing the NDC programme, they wanted to explore individuals '*in charge*' and develop the real potential that the area-based initiative offered of working differently and developing a community governance model with other partners.

This central theme of people being supported and empowered was mentioned in all the front-line-worker respondents' transcripts as key to why they became involved in the regeneration programme.

One of the respondents, Jo, who lived with a chronic, long-term condition had succeeded academically and completed a degree course, and an expert patient health trainer programme at Stanford University, but initially was still unable to find employment in the local health economy of her hometown. She wanted to bring her skills to work with her local community, and saw a potential pathway through volunteering. She was very interested in understanding and developing improved health through self-management programmes. Her transcript demonstrates an understanding of the dynamics and what motivated people, combined with her insight into self-efficacy, her buoyant interpersonal skills, and compassion to explore how a collective model could help drive the health agenda and change in NDC.

'On reflection for me it's all about individualism. It's my basis that I work from. I remember having a discussion with Kate (Lorig, Stanford University) a one to one and I'm sure she used the words- that her words were- 'quantum change'. The importance that an 'individual is moved to change.' I'm sure those were her words' (Jo, directly after the questionnaires, 20.5.2007).

The data from all four respondents refers to working on a one-to-one basis and within small groups to support individuals and improving self-efficacy strategies to help facilitate situations where people take charge. They also mention the importance of involving and helping people form collectives, which would help to build community capacity. By understanding and working on an individual basis, all respondents suggested that they understood the critical issues and barriers, the significant importance of public health strategies, such as involving people in cognitive behavioural change, and the dynamics of involving communities.

As a Public Health Practitioner, Joan had already seen a retraction of clinical services and was involved as a front-line clinician. She wanted to strengthen and renew her engagement within the NDC community by working within the health focus group and the community health, action partnership, to support the design and the delivery of the new health services. She discussed how she participated and engaged with the local people and the other front-line workers within the NDC forums to help them use their skills and capacity to design the new health programme. Contributing her own public health expertise, she stressed how important local community involvement within these forums was and also how health services could be localised and start to meet some of the growing unmet health needs in the ABI. The majority of Joan's clinical experience had been gained working to address the health and social-care needs of disadvantaged families. The impact of the retraction of health services from 1990 to 2000 was a catalyst for her to become involved in the NDC.

From 1998, Alice coordinated the first sixteen months' work within the NDC, helping all partners to work collectively to develop the bid for the partnership status grant. Her work included steering whole-system events involving the community to support the development plans with all key actors, then facilitating and redrafting the proposed development plans for wider partnership from discussions and amendments. This was a key role on behalf of the strategic partners towards achieving the NDC status for the city. Her transcript documents that her activities involved compiling and writing local and national reports, interfacing with strategic and operational partners, establishing the new structures, facilitating the six focus groups and servicing the partnership board. Alice enjoyed her role, a complex and demanding task which involved administration and people management, and she stayed for the full 11-year term of the NDC programme. This respondent expressed a wish that the NDC changes should

be recorded and the importance of learning from the process:

'*I think one of the things we talked about is to try and tell the story of NDC. Because I think, well people - well we know people come and go. Different people change and I think people forget what there was before as well.'* (Alice: 221 – 228)

Cross-regional restructuring of the corporate, multi-layered infrastructures to involve local people was a key role for one of the respondents. Lizzie's transcript shares her involvement within statutory restructuring to introduce local-area groups closer to the decision-making. Lizzie's data highlights the complexities she experienced in the adjacent NDC whilst she worked within the local community helping establish groups:

'...*what we thought was important was there was very few community development workers working on the ground in East Manchester. So we'd bid for money and been successful in creating some community development workers, and the start, the very start of the thinking around, looking at alternative governance arrangements. And I got the job of pulling the two together and so, that was back in 2001. I think that was probably early 2000/1'* (Lizzie: 19–29)

This job identified problems with harnessing community capacity and engaging local people in the decision-making process, and was twelve months ahead of the implementation of NDC programme in Wassail and Boothtown. Previously a social worker, youth worker and manager of the sexual health services, Lizzie began working in the Health Action Zone at the time that New Labour introduced the regeneration policies. It was from her position in the HAZ in a neighbouring area adjacent to the NDC area, helping develop and disseminate the participatory governance model throughout the region, that she became involved in the research. Employed through the strategic body, the HAZ, she translated and shared good practice both across the region and with central government. The data identified that in 2000, the new regeneration policies supported an integrated approach across the regional area and Lizzie had a key role with responsibilities for implementing the regions Local Area Groups (LAGs) and citizen's involvement in the developing health and social care agenda.

The respondents saw the NDC as an opportunity to get involved and deliver strengthened participatory engagement to the communities waiting for change:

'*they just needed a lift, they definitely needed something to help them get out of a rut and there were certain people in the area that have been in the area years – who wanted to do something about it*' (Joan: 57 – 60)

All of the respondents mentioned they anticipated that the new regeneration policies would reconfigure services and increase participation, resources, integration and directly impact favourably on reducing health inequality and deprivation

6.6 The respondents' experiences of the NDC partnerships and new opportunities

The Health Action Zones responsibility involved working with central government and also across the local region central and local government offices, with all the local actors developing partnerships and joint new opportunities to work on collective initiatives. This included partnerships involving members of parliament and all the major statutory and voluntary bodies.

I was seconded into the city by the HAZ and was the first joint LA/PCT appointment in the newly formed PCT. My joint role as a Health Development Manager within the PCT Public Health Department and the Local Authority Chief Executives Department was initially the only senior position representing health at the NDC Partnership Board between 1998/9. In 2000 , the Chief Executive Officer of the HAZ successfully secured the position of CEO of the PCT. The HAZ CEO had been instrumental in strategically supporting the work of the Pathfinder status and the NDC, and had line-management responsibility for my position within HAZ, until NDC status was awarded in 2000.

All of the respondents referred to the new NDC Partnership Board and focus group governance structures that the regeneration policy introduced (Figure 3.4). They mentioned that '*who*' was on the Board representing the health focus group work was critical to whether the actions of local people were represented effectively. Six themed focus groups were adopted as the mechanism for ratifying decisions and approving NDC monies, they met regularly and fed their plans and choices into the Partnership Board. The Partnership Board, which had to demonstrate membership from all sectors, was jointly chaired by a member of the community and the leader of the council. It was following the award of Pathfinder status that one of Alice's key roles became working with all the local actors, private and voluntary sector and strategic partners to co-ordinate the development of the ten-year NDC delivery plan. Once the

themed focus groups had provided their input into the NDC Partnership Board, the chair of the steering group then had the overall responsibility for identifying key issues, barriers and gaps. In Alice's transcripts, she refers to her role as a senior manager within the NDC and needing to use the skill set she had learnt within local authority planning and housing departments to coordinate the community partnership and the strategic partnership for the city. One of Alice's main activities was to coordinate the agreed-upon delivery plan across these different groups, forums and cultures whilst simultaneously having responsibility for monitoring and publishing the performance review of the delivery plan; a sensitive job, with political implications both locally and nationally:

'Well they [City Council] are very … I mean… they are very reluctant to sort of benchmark one against the other - and they don't go public, because it's early days' (Alice: 4-5).

Alice was referring to the City Council's reluctance to have the NDC Partnership financial governance and community governance scrutinised and benchmarked against the other 38 national NDC programmes.

Alice discussed her key role in facilitating the senior, strategic, partnership board, which in her view was the most consistent and strongest partnership throughout her time, and which had contributed to the success of the NDC programme because of the support received from the City Council Chief Executive and Leader of the Council:

'David Black [pseudonym] you know in his role has been supportive – I think because he really believes in the New Deal philosophy' (Alice: 91 – 93).

She reinforced that, in her opinion, you needed high-level, internal, local authority support and backing, from somebody who understood the political and strategic dynamics involved in joint decision-making, if you wanted to successfully devolve incremental power to the community.

All the respondents discussed in their transcripts that it was the passion and commitment from individuals, rather than organisations, that supported and therefore generated greater involvement and assisted the introduction of new models of change:

'The partnership was always about - almost always about the individuals.' (Alice: 122)

All the workforce respondents in their transcripts highlighted the importance of individuals as drivers and catalysts for change. They also discussed individuals, who were needed on an on-going basis to support consistent, effective communication across all sectors. The facilitation of communication role was undertaken by individuals rather than organisations, and played a vital role in the on-going success of the NDC. Alice went on to highlight:

*'I think in terms of the strongest support, the most continuous one, it has been the relationship between New Deal and a core number of committee board members, say in terms of partnership sort of thing and David Black actually. As leader of the council, David Black's orders, he's also been very loyal and supportive and [has] furthered links to the council with David facilitating the relationships with on-going, effective, vertical and horizontal communication. I would say that he has been consistent and consistent in terms of relationships with some of the other big player*s' (Alice: 102-113)

Jo described how she was looking to develop the empowerment model within the GP practice and in the new health training programmes, specifically focusing on people with long-term limiting conditions. She suggests that the opportunity of working within the regeneration programme helped her deliver the expert-patient programme:

'I didn't find it until I got to NDC until I found you and got the support there because I think you understood what I was interested in and you could see how it could work, and within a kind of community - whatever you want to call it - from me it was always about the individual.' (Jo: 323-337)

My role involved working and communicating across both the vertical and horizontal axis, across the newly emerging spaces involving all local actors under the continued leadership of the HAZ/PCT until 2004. The complex reorganisation within health and social care, together with wholescale changes and with increasingly conflicting targets and monitoring processes, impacted on involving community participation in the NDC. The HAZ CEO and I had worked together, developing the agenda in the regeneration patch and we had a full grasp and growing understanding of how complex the governance dynamics and new models of working were to implement the NDC programme. Until 2001, she was my line manager, and in 2004, when she left her position as the CEO PCT, she suggested:

'I'd like you to move from your role working within the community and take up a position

within the senior directors and management here within the PCT. The internal directors don't understand at all the model that we are developing - I need you to support the workforce change from inside the PCT.' (Ms Frida Higgins [pseudonym], Chief Executive Officer PCT, April 2004)

I left the NDC programme in 2004 and, in her transcript, Jo describes her new senior, line manager, as a corporate PCT manager who did not understand the new community governance models and was '*the wrong tactical manager*' (Jo: 194) and in her view was *'out of sync'* (Jo: 257 – 259) with the whole new way of working. Jo also highlights the importance of individuals' support *'when you left - communication just went'* (Jo: 334-335). The responsibility to all the community was enshrined within the successful partnership and the NDC ten-year strategy. There was an agreed set of participatory processes that were developed and published in 2001 against outcomes and milestones (NDC delivery plan, 2001: 29-40). With the newly incoming Primary Care Trust in 2003, tactical and strategic managers had a set of targets and central government directives.

The respondent, Joan, highlights that, in her view, *'PCT was taking over the whole affair' (*Joan: 180 – 187) and was not working closely in partnership with the community. She also expressed concerns about lack of communication with the community and the decision-making process around how the NDC monies were spent.

Alice discusses the changes of membership, including the NDC Partnership Board, and her insight into the disruption those changes caused. She shared her view about what happened when people with specific passions and commitment to community governance left both the NDC programme and the NDC Partnership Board:

'The partnerships were almost about the individuals' (Alice: 12) *'there's been ups and downs, same with the health, I mean for example Amanda Roberts [pseudonym] has been a mainstay on the board, but in terms of more operational links this has been a problem, as I said before, because of all the changes in personnel and stuff' [reconfiguration of PCT from Community Trust]* (Alice, 124 – 129).

Amanda Roberts had recently taken a senior strategic position in the newly reconfigured PCT and Alice highlighted that she attended as the health member on the NDC Partnership Board regularly since becoming a PCT Deputy Director of Public Health. However, problems arose as she did not link with the operational front-line

staff working in the NDC area or communicate board matters to them. There was increasing demands for the PCT and LA to submit health and welfare monitoring returns which did not have to explicitly identify or establish standards of devolving participation to the community. A professionally-led response developed with middle management replacing community representation with the new incoming PCT strategic management.

6.7: The NDC health action group projects

In their view, the workforce respondents acknowledged the different ways of working and what was achieved as programmes developed in the early years, from 1999 to 2004. Within the NDC health community, these included the work that resulted from the 19 health action groups, including the successful '*Can Do'* projects, child health play workers' appointments, the new primary-care-led health centre, and peer and volunteer-led, health training programmes. The workforce respondents' transcripts document that, in their opinion, these projects supported and increased engagement and participation with front-line workers and how local people were involved in all aspects of the conception, design, delivery and resource allocation decisions of these local health programmes.

By the time the PCT was constituted and senior directors became involved at a strategic level within the NDC, the operational Health Focus Group (HFG) partners had already established their own ground rules and a way of working and communicating. Relationships within HFG and NDC had been developed and a high trust culture had been established between all the actors. The PCT was reconfigured in 2002 with the senior manager's appointment and the tactical, middle managers coming into post in 2003/4. This was when central government Treasury policies introduced new, public-private-finance-initiative decisions regarding health services' estates into the NDC area in 2003/4. Senior management representation from the reconfigured health services came into the NDC decision-making, partnership board in 2003. The data analysis indicates that this introduced a hierarchical management style into the NDC programme, shifting away from the previous participatory model. Previously, the respondents had worked in small, operational clusters involving a range of different actors using matrix management and action-learning techniques. These incoming tactical, senior PCT managers had a responsibility to central

government to deliver on the targets and to monitor returns. By late 2003, this included both the Office of the Deputy Prime Minister monitoring returns on the NDC and also the Treasury Department monitoring returns of the NHS public-private-finance policy initiatives. The NDC output monitoring returns were not only linked to resource allocations, but also offered comparable data nationally across the NDC programme, publicly identifying specifically how Wassail and Boothtown NDC was progressing in relation to other NDC's.

Alice's role on behalf of the NDC included compiling these monitoring returns and, in her transcripts, she highlights the challenge of demonstrating that NDC had made a significant difference to the health and well-being of the population. She commented that in her data monitoring returns to central government, some of the difficulties included:

'not describing what the NDC funded activity should be, but identifying this as the health issue or probable opportunity for improvement. Visioning how do the population want to be in 5 years' time 10 years' time. Which could include the thinking 'Well, actually, how are we going to make difference?' (Alice: 267–273)

6.8: Community involvement and models of change

The transcripts' analysis demonstrates that the respondents were involved in the preparation work with the community, both building models for involvement and implementing new participatory techniques with wider members of the population to enable them to become involved. Jo describes how she was actively working in a general-practice, governance board involving patients in other parts of the area in a voluntary capacity. She chose to move into the NDC regeneration patch because she saw an ideal opportunity to develop a health-involvement model which involved greater decision-making by patients:

'I was quite optimistic, People who were on a similar level and work to me, seemed like they were local people, that had aspirations for themselves and also for others' (Jo: 59-61).

The lead-in time and preparation between applying for the Pathfinder status and being awarded the NDC allowed strategic partners within the local authority and HAZ to understand the current, community-engagement models being used to enhance and

strengthen all the opportunities for health and social engagement. Initially, structures at an operational and tactical level were actively remodelled to allow and measure greater community involvement and joint working. The workforce respondents were operationally involved in implementing these new structures. Their transcripts demonstrated that they had all been involved and retrained as necessary:

'*what was important (about the NDC) was to look at how we could set up participatory structures that would involve local people in ways to influence the future direction of the PCT, also to be up to take part in decision-making and create more opportunities so they could become involved in the decision-making.'* (Jo: 14–19)

The analysis of the workforce transcripts indicates that all of them were passionate and optimistic about the possibility of this change offering solutions by collective working between front-line workers and local people. However, one respondent, Joan, describes the involvement of her senior line management in relation to communication with the community as non-existent and as '*leaving the community in the dark'* (Joan: 183–187).

The workforce respondents discussed how effective communication and shared decision-making and power-distribution impacted on community resilience and on both their own and the community's capacity to participate. Within the first four years of the NDC programme, the local community and the front-line workers had had their expectations raised as they were active participants in the design and planning and implementation of the new health programmes. Joan describes all the other workforce groups including housing, employment, health and church partners all coming together at a number of different whole-system events in the planning of the health programmes (Joan: l72–79). She also highlights the importance of different elements of the community being involved, specifically elderly people's involvement in planning safety measures introduced within the physical infrastructure of the new community gardens (Joan: 398). The appointment and introduction of community animators was widely welcomed as a new model of community engagement which funded local people out of NDC to interface between the wider community and NDC processes. Each community animator's role involved direct responsibility for representing a different area of the community's views. (Joan: 441)

6.9: Integrated community approaches

When the local authority was preparing the bid with the HAZ to be submitted to central government for NDC partnership status, I was very aware that people had been consulted on their views and asked to participate without any outcome. In order to help develop a new model with an integrated approach, we could not afford to get this wrong with any level of tokenism in engagement or participation. One of the successes highlighted by Joan (pp. 106–118) was the inclusion when all the NDC workers and members of the local community were invited to help design the NDC plan:

'*It was a very well attended affair that day, a day to remember, it was very exciting to watch the buzzing going on then, there was little sort of offshoots, with groups continuing working together. Meeting up doing different things, working on different health topics'* (Joan: 113–117).

In the early planning of the health programme, to capitalise on the participation and commitment and to harness the involvement of small groups of local people and front-line workers, the HFG and CHAP groups introduced the '*Can Do'* projects. The concept of the '*Can Do'* projects had been approved by the NDC board. These projects involved groups of three and four people identifying a health project that they were passionate about, costing it against an activity plan and bidding for the funds. This programme was introduced and operationalised between 2001- 2003 and facilitated through the HFG. Not only did this energise people to seek solutions to their health issues, it handed the tools to them and introduced participatory budgeting into NDC. Approximately thirty-five '*Can Do'* projects were approved, with a maximum budget of one thousand pounds each and, in 2008, Joan was suggesting further '*Can Do'* projects as possible solutions to helping support integrated, joint working (Joan: 509).

6.10: New models of community involvement

Local area groups (LAGs) were instituted in 2001 to improve communication between the community, local government and health partners. Whilst respondent, Joan's role meant that she had core involvement in the design and implementation of the new LAGs in Manchester, Jo was also involved as a volunteer and as a local citizen in the city's LAGs.

Alice's transcript identifies that *'there was early discussions and I think people were*

(just beginning to) understand that there was this thing called 'community governance' in 2000. In 2004 there was no vision on it, was there? All that work we'd done on models of community governance.' She explores the changeover of health staff working within NDC and representing PCT partners on the board:

'I did think that was where Rose Lee was actually going to come into her own. Because she was brought into it as the Director without portfolio for the PCT, do you remember? I mean, I mean Rose was very passionate about it (communities in control of health decisions). I think it was a heavy struggle with making the philosophy real. Actually how do you make that vision real? And we had started a little bit off there was a commitment and still is a commitment actually to service the governance structure – if you look at partnership' (Alice: 352–363).

The strengthened, community governance model of primary care health services was interpreted within the NDC patch – the first within the city. Between 1999 and 2004, the new GP-style practice was moving away from the doctor being employed within his own business, and being appointed through the PCT. This meant they were salaried GPs with accountability to the targets and standards that were established through the PCT. Joan was delighted at the proposed changes and a quote from the transcript suggests '*people were given choice and time*' (Joan: 220–222).

Although it is referred to obliquely by the workforce respondents in the transcripts, the community health action partnership (CHAP) is explored further in Chapter 7 which discusses the community respondent's views.

6.11: The achievements and the barriers

As the new NDC regeneration health-policy work started to be implemented, all the front-line and workforce respondents recorded that they were eager to be involved. They mentioned wanting to become more engaged to better inform themselves about what the regeneration programme meant in reality, and saw the need to raise their own awareness, as well as looking forward to working in partnership with the community. Unfortunately, the delayed reorganisation of the major, statutory-sector, health-service providers from the previous Community Health Trusts into the new Primary Care Trusts, with their new commissioning responsibility, was not done simultaneously with the introduction of the NDC programme. This was understood by the respondents as meaning that, because the appointments of the senior personnel

in the PCT were delayed until 2000/1, they came with no knowledge of the participatory ways of working with the community that had been operational since 1999. The experiences of the NDC suggests that, prior to this, the operational workforce and the local community had worked together. When these tactical senior and middle managers were appointed internally within the PCT, the workforce respondents commented that they had little knowledge or experience of the previous two years' operational work that had taken place in Wassail and Boothtown NDC. The data suggests the authority and power was retained by the newly appointed professionals, with a shift moving towards a professionally led way of developing representation within the NDC. In the respondents' views, the incoming tactical managers did not understand the importance of maintaining effective communication and the power shifted away from the real joint participation between front-line workers and local people, who, up until that time, had been closely involved in making NDC health decisions, back to it being professionally-led. All of the workforce respondents valued the involvement of the community and were disappointed as the community appeared to have been bypassed:

'*To try and run it, run it alone without other people - you can't do that! You need everybody else involved.'* (Joan: 284-286)

Conversely all four respondents identified problems that arose with the staffing appointments in the newly-formed-PCT, and the new senior managers who then joined the NDC Partnership Board in late 2002. Two of the respondents mentioned specifically that the new managers had little or no apparent understanding of the way the previous senior health board members had worked. Between 1999 and 2002, a strong participatory model had evolved in the HFG NDC which involved working together with a high-trust culture. This high-trust culture developed and was nurtured across all the stakeholders because time was allotted for all participants to understand and explain things before decisions were made. Now, the respondents highlighted that the senior, tactical and strategic, health managers appeared to be making decisions autonomously, and shifting back to a previous way of working. All respondents specifically discussed the potential of the new partnerships and the impact that the middle and senior managers had on the potential for the evolving work to address health needs.

6.12: Impact of delays in the Primary Care Trust joining the New Deal for Communities

By the time the Pathfinder/NDC programme was introduced, the operational front-line workforce had developed ways of working autonomously and flexibly to respond to the health needs in the regeneration patch. In the first two years, the scoping and exploration of the local communities' views on what were their own public health needs and how they saw these being met had been undertaken. An NDC health plan including clinical, community and complementary programmes had been established and approved as part of the NDC ten-year delivery plan.

'*We brought all health professional, social workers, housing people, education people, everybody that works within the area – that had contact with people – that to let them know that this money was available, and it's all about new ideas on how it should be spent. It was very exciting to watch the buzzing going on in the little sort of offshoots, little groups that were doing things differently, working out different. And I think I did all the public health work.'* (Joan: 106–118).

The workforce and community respondents' data discusses this working together differently across all 3 analysis chapters, incorporating aspects such as community governance, social modelling and strengthening community assets. However, as the core NDC Partnership Board had had poor representation from the PCT health partners prior to 2002, where the specific views of the front-line workers and the community had been extrapolated from the health focus group and fed into the NDC Partnership Board. This all began changing in 2002 as the senior PCT directors began to be involved in the process.

The views of the workforce respondents were that they had worked, comparatively unconstrained by management until that time. Consequently, as they highlighted, in those first few exploratory years within the NDC, they had developed new, collective and autonomous ways of working. This was a very different model from the previous 'top-down' hierarchical management model that had existed within health services. The respondents described how they had jointly, with all partners, been allowed to develop a public-health, community-needs assessment. They discussed developing this new model using an asset-based, participatory approach with the health focus group actors. The respondents documented that this was what, in their view, had

resulted in a positive change to the previous way of delivering health services. It facilitated and also supported an engaged and socially-active, involved group of community members. Both the health focus group and community health, action partnership had nineteen, separate, health-related work streams by 2002/3. Respondent Joan commented that individuals and communities working together had enhanced the capacity-building within the NDC community. However, in 2002, this model, they suggested, was largely misunderstood within the incoming PCT senior-management team. The impact from the new, tactical management was to appear to take over management of the work streams of existing projects, rather than working collaboratively:

*'Because the city PCT has obviously got quite well involved with New Deal then and the monies, and non-decision-making, and I felt slowly but surely they seem to be taking over the whole affair and leaving all the people who had done all the hard work in the community left standing and also leaving them in the dark.' (*Joan: 180-187)

This lack of understanding or working together in partnership by the healthcare senior management of this new, integrated, joint working and the intentional development of diverse, community governance models within NDC persisted and had an adverse effect on the workforce respondents' morale and involvement. Building community capacity had been part of a discrete research project in the city; however, prior to the introduction of the NDC programme, it had been contained within specific projects, rather than as a whole-system process. When her new senior tactical manager restricted her clinical role and communication with the community, Joan experienced distress and she describes how she had thought the delivery of the new primary care practice was supposed to be: *'It was a new innovative practice which was completely different to the way practices had previously run in Wassail and Boothtown. Instead of it being a business it was supposed to involve everybody' (*Joan: 372–379).

This new model of working together within participatory, open, neutral spaces that had been nurtured by the HFG and NDC took place between 1999 and 2001/2 Front-line workers and local people developed a high-trust culture during this time. Whilst tactical, middle management was noticeably absent, some strategic managers and political partners supported these positive workforce changes. Joan describes how she felt she was supported directly by the city's Chief Executive of Council for voluntary

services and also by the local Member of Parliament. However, when the new PCT senior, tactical managers were appointed, respondent Joan discusses after, over two years of working together, how her relationship with her incoming PCT manager had broken down:

'It was too late, a lot of, a lot of animosity developed between myself and the manager by then, and I was certainly somebody who she was gunning for and I was then the one she wanted to get rid of. And eventually she ground me down, she was quite ruthless, ground me down bit by bit, but it was all too much for me and yet I had done so much hard work in that year.' (Joan: 380-387)

6.13: Legacy post NDC 2011

Analysis of the NDC minutes revealed that, early in the programmed delivery of the partnership, it was debated whether the board wanted the NDC to undertake a legal change moving away from and becoming independent of the City Council. This would have given the NDC Partnership Board greater legal responsibility and more financial autonomy. Alice was operationally in her Deputy Chief Executive role when these debates took place between local actors, NDC and the City Council. Alice retrospectively discussed what she thought was missed in the early days when there was a greater pressure to deliver physical infrastructure changes such as within the housing agenda within NDC. The processes that underpinned the initial design and development of the individual NDC programmes could have included incrementally devolving an ability to have a level of self-sufficiency and powers to the community and generate income. She commented *'We could have had something for the community, you know, that had a real power base for the community really'* (Alice: 314–317).

However in 2007/8 the NDC Partnership Board remained under the legal governance of the local authority and did not become a stand-alone separate entity.

The documentation revealed the communities' aspirations for the Partnership Board to become a separate entity, and that discussion concluded that the NDC would have greater influence as an arm's-length management structure for delivering the ten-year delivery plan. However, the research analysis confirmed the City Council retained its financial and legal management throughout the eleven years of the programme. As Alice retrospectively discussed this as a missed opportunity for devolving more power

to the community, I asked a direct question pertaining to this about the NDC legal status, and her response clarified the status of the Partnership Board:

'Yes it's not an incorporated body as it was to have been. I mean it's still a decision-making vehicle within New Deal but it hasn't got any legal status, you know. None of it's got any legal status. Still, on the bright side, I think in terms of the way Tom operates (NDC CEO). I think it was his, a deliberate decision, to try and be slightly autonomous. I mean we want the best of both worlds really' (Alice: 49-61).

The early discussions with the development of the partnership bid in 1999, prior to the New Deal status being awarded, had talked about the possibilities and ideas related to principles of devolving power and autonomy to the local community and local actors. The CHAP group had become a community interest company with legal responsibility for budgets and staffing. Alice's comment regarding the '*best of both worlds really*' is referring to the NDC partnership board not becoming a legal entity as preferable because it was the '*safety ne*t' of the local authority, with its continuing support and resources within the wider NDC work, which would be the legacy after the NDC grant programme finished.

6.14: The workforce's individual personal views on the NDC achievements

All of the respondents mentioned the new health centres, however, they state that the original concept devised with the community in the HFG plans identified them as having a clinical, community and complementary element inside each of the new proposed health sites. Joan had moved roles from that of a health visitor to a public health practitioner nurse in one of the temporary new health sites before she left the NDC area. She described working in NDC in the later years as very difficult:

Joan suggested *'I was the only one keeping it together'*. She commented on my role as the joint worker '*no-one had the responsibility for vertical and horizontal communication, which after you and I left the programme in 2004 it ceased'* (Joan: 164–167). While, conversely, respondent Joan suggests she did achieve the introduction of the new model and *'never gave up – kept with this all the time'* (Joan:121–123). Jo also stated, *'I don't know, I don't think I knew it to the extent I know now and being absolutely honest there isn't much you can do about it other than the individual stuff, so I think what I've learnt, what I've learned is quite depressing I don't*

think, I don't think it was enlightening just confirmed that life is cheap' (Jo: 437–476 & 484–486).

Alice discusses in her transcript the importance of telling *'the story of New Deal'* (Alice: 223). This research is telling the narratives of these individual, lived experiences.

6.15: Conclusion

In this chapter, I analyse the workforce respondent's data and identify the key themes that emerged. Moving the analysis through a series of different processes allowed me to identify local dynamics involved in communities participating in delivery and models of change in health care. My analysis suggests that the initial rationale for the workforce respondents' involvement in the programme was with the intention of improving access and health and well-being practices locally. In addition, the new NDC programme helped by leveraging additional resources into the geographical area, whilst at the same time offering an opportunity for the front-line workforce to work with and involve local people in partnership to deliver the new health models. The 19 projects discussed and designed in the new participatory spaces allowed the local workforce to work in joint partnership with the local people.

It was the newly-established, NDC health group forums that supported the development of close, working relationships between front-line workers and local people between the years 1999–2003. This demonstrated an important dynamic between the community and the statutory sectors. The local workforce learnt to identify, while actively working with the local community, their own health needs and clarify what they would like introduced as potentially a new way of delivering health services locally.

New models of alternative community governance involving local people in decision-making and delivery emerged during 2001-2004, within the new health action-learning sets and spaces. The local workforce respondents began to develop and introduce new models of working locally within community health service delivery, together with greater involvement of local people in new, joint models of clinical, community and complementary therapy services, and with decisions about resource allocations being taken locally. Whilst in the initial phase delivery of the NDC programme the research recognises that the front-line workers and the local people did identified new joint ways of working with community governance, social modelling and in areas strengthening

community assets and working in partnership, this changed when the PCT tactical staff came into post. Delays in the reorganisation of the health services tactically and strategically resulted in a poor understanding of the NDC way of working. When senior PCT staff got involved in 2002 the front-line workers and the local people position shifted in relation to decision-making and power-sharing.

The workforce respondents' analysis also clearly documents a desire to continue post-2004 to address local health needs using the new, participatory, co-productive model and the importance of leaving a legacy after the ten-year programme finished. These themes are discussed further in Chapter 9.

7: Participation in the NDC – Wassail and Boothtown: an analysis of the community respondents' views

7.1: Introduction

Chapter 7 will analyse the community respondents' experiences of the new participation structures arising during the NDC delivery of the '*joined-up'* social and political policy discourse that emerged with New Labour's Third Way over the longitudinal timeframe from 1998-2007.

The NDC delivery plan stated, '*The aim of introducing NDC programmes was initially to ensure greater stakeholder involvement and increased contribution of greater community participation in service delivery' (NDC Delivery Plan, 2001).* This analysis questions whether the NDC programme did offer greater opportunities for involvement for the local respondents in determining their own local healthcare priorities and in the delivery of the NDC regeneration programme. The data analysis concentrates on a) why the local population became involved and b) their experiences with involvement in the joint, participatory working, and the new democratic spaces and health infrastructure changes resulting from New Labour's introduction of the NDC regeneration policy. It explores whether the NDC offered a transformational space for change by involving local, civil society as wider partners in the decision-making process and examines the impact of the local community participation in health care.

I first met two of the community respondents, Keith and Brian, in 1998 as they became involved in Pathfinder status. I continued to work with them throughout the time I was engaged in Wassail and Boothtown. The six other community respondents I met a year later in 1999 as they became involved in both the development and design of the CHAP or as they contributed to the HFG in 2000. I was involved with the community respondents throughout the years 1998 – 2004, and I maintained contact with the respondents, as a researcher, until the final respondent questionnaires were collected in 2007 (Appendix 2).

The data analysis in Chapter 7 is based on a series of interviews with eight local people living in Wassail and Boothtown during the period when central government introduced their regeneration policy (1998-2007). Throughout the life of the NDC, the eight local community respondents made individual decisions that suited their specific requirements related to how to record and reflect on their involvement in NDC. These

included attending action-learning group time, one-to-one reflective sessions, research diaries, journals and notes. This research study is positioned inside the knowledge praxis with the analysis of the respondents' views located within the wider structural analysis as the respondents were involved on an on-going basis in the NDC programme (Chapter 5, Figure 5.1: Praxis Change Model). Using the permission within the NDC policy, I supported local actors within the strategic environment to communicate how they wanted to enhance the community governance models within the regeneration area. We used the health focus group (HFG) and the community health action partnership (CHAP) as open spaces for local actors to build capacity, plan, coordinate and evaluate the regeneration health programmes they wanted including in the 10-year strategy. This reflexive praxis model was developed incrementally and used by respondents collectively and individually as they adopted reflective-practice techniques and used action-learning groups for reflection and to support each other. With the respondent's permission, I have used their written materials that emanated from these intersubjective spaces to collect a secondary data source, in addition to the eight interview transcripts, to enhance and further inform the research into exploring the lived experience of the local people's participation in delivering the NDC health programme.

Using the same techniques as in Chapter 6, I transcribed, cross tabulated and consolidated the data to collectively explore the community respondents' views, focusing on the joint themes which emerged from the transcripts. Analysis and interpretation of both the transcripts and the secondary data source involved coding, categorising both primary and secondary stakeholders, records and documents to robustly capture and identify the emerging themes (Appendix 1). I have also included quotes from background documentation to inform and enrich the context of the data analysis across the longitudinal timeline. The emergent themes captured in this chapter occurred as the New Labour government strategically introduced the NDC regeneration policy. It captures the eight community respondents' experiences of the delivery of the NDC programme and observes the actual changes that occurred within the local health services in the area-based initiative. As with the workforce respondents, the analysis focuses on how these local people experienced the new structures for participation and the partnerships and opportunities created by the NDC. It is their '*inside voice'*.

7.2: Key characteristics of the eight community respondents

A requirement of the NDC policy was to increase community involvement in the delivery of the programme. New Labour's Third Way regeneration policies stipulated that local citizens from within the neighbourhood had to be involved in partnership with the delivery of the programme and in the decision-making process. I purposefully chose a sample of eight community respondents who had been involved from the inception of the NDC policy within the area, initially prior to the award of the Pathfinder grant. This sample of eight community respondents had contributed to the development of the Health Focus Group's (HFG) agenda across the longitudinal timeline between 1998/2000 and 2004 and all of the respondents were still involved in the NDC programme in 2007. All eight community respondents interviewed had become involved in the design and development of the Community Health Action Partnership (CHAP), a community group which was an affiliated working group linked to the NDC HFG. In 2001, the CHAP group developed into a Community Interest Company.

Table 7.1: Characteristics of the eight local community respondents and their roles in the NDC

Pseudonym	Background information	Role in NDC
1.Kate	Kate is a 52-year-old, married woman initially working in an administrative /receptionist capacity in the local 6th form college. She first became involved in the Pathfinder bid in 1999 and, by 2000, was actively involved in the NDC emerging structures including membership of both the HFG and the CHAP board. Kate secured full-time, paid employment within the CHAP as it developed into a Community Interest Company in 2001.	Kate was CHAP secretary and lived in Boothtown. She was in the HFG Action Learning Group and developed and facilitated the '*Can Do*' real-time, community change projects 2000/1.
2.Keith	Keith is a 54-year-old, single man who	Keith's roles in the

Pseudonym	Background information	Role in NDC
	had been a painter and decorator. In his early career, he had been employed as a social worker. He lived with a long-term, mental health condition and had left the profession permanently. Keith first began working with the Health Action Zone in 1998, exploring the possibility of Wassail and Boothtown becoming a Pathfinder site. He reintroduced a local fresh fruit and vegetables project into the NDC area, Clockwork Orange that he designed and delivered. He also went on a national programme, training, supporting and developing entrepreneurs within communities.	NDC included the Health Focus Group, chairman of CHAP and member of the NDC Partnership Board as the community representative from 2001- 2010. He was in the HFG Action Learning Group and facilitated the '*Can Do'* Real Time Community Change projects 2000/1. He also ran Clockwork Orange and lived in Boothtown.
3.Seren	Seren, a married woman in her mid-30s, first became involved in NDC administration in March 2001. Previously she was unemployed. Initially, she took an administrative job in the first temporary offices in Wassail House, and relocated with the NDC team, taking a full-time NDC office manager's post until 2003, when she left to start her student nursing. She worked closely with all the officers and personnel seconded to or employed by the local authority in NDC.	Seren and her family lived in Boothtown. She worked in the NDC, latterly, as the office manager.
4.Rose	Rose was a 19-year-old, vibrant, vocal	Rose was a

Pseudonym	Background information	Role in NDC
	teenager who took on a paid position in July 2000 within NDC as one of three community animators in the NDC area. As an outreach worker, she was responsible, for collecting local people's views/data on what they wanted in the NDC. She collected community views using public spaces, events or on a one-to-one basis to access qualitative & quantitative data from the 10,000 population living in the NDC area.	community animator who lived in Wassail.
5.Sally	Sally was a local shop assistant who went on to become one of three community animators, employed by the NDC collecting the data for the formation of the 2001/2011 NDC Delivery Plan. A recently remarried 50-year-old woman who had lived in the area for 20 years, she had been active within her local community prior to the Pathfinder status.	Sally lived in Wassail and was a CHAP member and a community animator. She was in an HFG Action Learning Group and developed and facilitated the '*Can Do*' Real Time Community Change projects 2000/1.
6.Ann	Ann is a married woman born in 1932, who had run the local greengrocer's shop in the Boothtown ward her entire working life. She had onerous responsibilities as a carer for her elderly partner and was actively involved in CHAP and the NDC Health Focus group.	Ann was the first CHAP treasurer, member of the HFG and was living in Boothtown.

Pseudonym	Background information	Role in NDC
7.Brian	Brian is in his mid-50s and is living with multiple, long-term conditions. He became involved in 1998, prior to the NDC Pathfinder status. He was committed and fully involved in helping develop the initial Pathfinder bid, health focus group agenda delivery plan and the CHAP group.	Brian was on the CHAP board and Treasurer and member of the HFG. He undertook national Expert Patient Programme training to become a peer volunteer tutor. He lived in Boothtown. In 2001 he helped develop and facilitate the '*Can Do'* real-time, community change projects.
8.Noreen	Noreen was in her early 50s with multiple, long-term health needs. She was married to Brian and became involved in 1999/2000 prior to award of the Pathfinder status.	Noreen was on the CHAP group and, initially, the HFG. She designed and started the peer support '*Sugar Free'* diabetes group. She undertook national Expert Patient Programme training to become a peer volunteer tutor in 2001. She helped develop and facilitate the '*Can Do'* community

Pseudonym	Background information	Role in NDC
		change projects from 2000/1. Lives in Boothtown

7.3: Why the community respondents participated initially

Overwhelmingly, the analysis of the eight community respondent's data indicates they initially became involved to make a difference, because they wanted to support an improved health service which would be available within their neighbourhood for themselves and their families and that they wanted a say in the design. '*I got involved because this can be a different initiative to make things better for the local people and give people a voice*.' (Rose: 44)

They became involved because they liked the community that they were living in and they wanted to contribute to it; the data also demonstrates that they understood the wider, adverse effects of the poor quality or lack of services on their own and their communities' health and well-being. All eight of the community respondents' data also separately indicated that experiencing the NDC programme gave them, individually, an opportunity to be involved together in the CHAP and HFG and to help to translate accurately their communities' aspirations to the local authority and the health sector and also to be part of resolving the problem of the lack of health and well-being services in the areas.

'*It was to make a difference in the area, a difference from the lack of services and make a difference to people's lives, make a difference to their health.*' (Sally: 250–252)

7.4: Why the community respondents participated in NDC programme: key findings

7.4.1: Additional resources

The analysis identified that all the respondents participated in the NDC programme because they wanted to secure additional health resources for the area. Five of the respondents had historically been actively participating in volunteering within the community prior to the regeneration programme coming to Wassail and Boothtown, while three respondents had never been active within either the health sector or

community development in their neighbourhoods before NDC. However, all of the community respondents' transcripts mentioned understanding that with the new policy came additional resources and they expressed a desire to help to get other local people involved by asking their neighbours in the wider community what changes they would like to see because of the new £53 million in funding coming to the regeneration area.

7.4.2: Improve health facilities in local area and listen to what we wanted

The community respondents' data documented that the introduction of New Labour's NDC regeneration programme did offer, for the first time, an opportunity for local citizens to participate and meet together to collectively identify their health needs and design and develop their own plans with front-line workers and managers. When the first open meetings discussing the Pathfinder bid were introduced to the local population, one respondent enthusiastically offered to become involved.

'He (local neighbour) said, "If you want something done, do it your bloody self" that's the only way you can get something done - that's right - so we did!' (Noreen: 96-99).

They all documented how they felt they had a supportive space, both within the health focus group and in other spaces such as the CHAP group, to voice how their health needs should be accommodated. One respondent, Sally, documented that she became involved because she believed that they would actually listen to the evidence that the community animators brought back from the community. In addition, she enjoyed getting the community involved and wanted to actually make a difference: '*People always complaining there wasn't enough GPs in the area, and there was no health facilities. So we worked with a group of people and alongside the health focus group to get services, health services and other services that want to see in this area - without having to travel out of the community'* (Sally: 79–86).

The HFG membership included both front-line workers and local people and the design and development of the NDC health-stream work was generated though this forum. The HFG undertook a Community Public Health Needs Assessment (1999-2000) that the local community and line-workers participated. '*I got involved originally because we thought we could make a change to the community in the area, it was really enlightening the discussions we had, sharing and discussing the problems*.' (Brian: 24)

The eight community respondents lived in the local NDC population across both the two distinctly different geographical adjoining wards of Wassail and Boothtown. The data analysis identified that the respondents all participated in the programme because the open spaces they shared helped them identify the health needs and they wanted them met by the NDC health programme. All the respondents, either from the north or south of the NDC area-based initiative, identified very different health priorities and both verbalised and documented this. They specified problems such as the lack of access and proximity to the area's existing health and well-being provision. They also raised the health issues this raised for themselves and their family and the poorly served local community.

One respondent, Noreen, was living with insulin-dependent type II diabetes with peripheral damage to her hands and feet, which restricted her mobility and made her susceptible to repeated renal infections. Her experience of both the local community and hospital health services energised her to help improve local provision. Additionally, she and her partner also wanted to work specifically with younger people in the NDC area, and Brian identified that there were very few facilities for them:

'*We thought we could make a change to the community in the area. So much going on, it was unbelievable with the vandalism and the young people and under-age drinking you know. All right fair enough, there was nothing for the kids to do-you know? I mean I must have been, I must have been one of the lucky ones, because when I was a teenager we had the cinemas, youth clubs, you know. Weren't so much disco's, but we did have dances you know. These days there's nothing for them to do! Only go round and kick the hell out of the bus shelters made out of glass! You know and then they come and then moaning it costs so much to replace them, why do they make 'em out of glass in the first place?'* (Brian: 24-40).

7.4.3: Working together with neighbours/local community

All of the eight community respondents' data mentioned that they were enthusiastic about participating in the new spaces the NDC offered, and it was important for them to volunteer in the early stages of the programme. '*That's right and he, Paul O'Sullivan, went (to the local meeting). Yes, it was when Paul stood up and said he wanted some volunteers to join a group, join a starter group - so we got involved*.' (Brian: 92 – 90). All of the community respondents lived with a long-term condition or had carer's

responsibility and all indicated they became involved in the development of the health-focus NDC work because they felt it was something they could contribute to. At the inception of the NDC process, the analysis documents how the respondents became committed and fully involved in helping develop the HFG agenda delivery plan and the CHAP group. The CHAP group emerged from the praxis change model early in the development of the Pathfinder status in 1999/2000. CHAP continues to operate today as a community interest company. The space that the CHAP group emerged from was managed and directed by local actors from the NDC community. The exchange of knowledge and awareness documented within the eight research respondents' transcripts demonstrates that the group had the characteristics of sharing power, effective communication, trust within the membership using reflective practice, consensus decision-making and conflict resolution techniques. The CHAP group has been exceptionally successful and transferable learning emerges from this aspect of the research.

Most respondents understood that, for them, the importance of being active citizens meant that the NDC programme could make a difference for themselves and their neighbours. One respondent had lived and worked in the NDC area all her life, apart from when she had been a land girl in the army during the war. She owned her own property, had run the local greengrocer's shop and had an onerous carer's responsibility for her elderly partner, when she became actively involved in CHAP. As an active citizen with a wide group of friends with different interests and ages across all generations, a respected, trusted and a lively, energetic woman, she volunteered consistently, even with her carer's demands, sometimes facilitating the complicated open space events which involved meeting and gathering information from multiple members of the local community. '*Why did I get involved in the NDC? Well on retiring I had lots of time…. And I got involved because I love people!'* (Ann: 47–48).

7.5: The respondents' experiences of the new structures for participation

7.5.1: Experienced inspirational leadership

As part of the bigger picture, the community respondents all understood the positive influence during the years 1998 to 2001 that the HAZ Chief Executive, Frieda Higgins [pseudonym], had as she strategically steered and supported the community participatory approach in the ABI. It was under her management, as the PCT Chief

Executive, that the community respondents' data recognised and appreciated her inspirational leadership. '*We had all the relatively important people on board [supporting us participating]. We had chief executives of the PCTs, we had the chief executives of the hospital trusts, we had MPs, councillors, community activists; everyone wanted to be a part of us. That was what really gave it the buzz'.* (Kate: 102–108). In the first years of the NDC programme, the HFG programme and the CHAP group felt that they were recognised and this was when they achieved the most. Both the CEO of the newly formed PCT and the local Member of Parliament met with the CHAP group on a regular basis. All the community respondents refer to the importance of this commitment from the leadership. A local resident commented on the pivotal role that I had in galvanising the CHAP and the local community to work effectively.

'*The [Health Development Manager] role was integral to the success of both CHAP and City PCT working in partnership… She was an inspiration, she inspired people, she inspired everybody who she had contact with*.' (Prashar, 2004).

By May 2001, the joint work assessing the community public health needs from 1999-2000 had informed the HFG Community Health Strategy plan and it had been approved by the NDC Partnership Board. Two of the respondents documented this new experience of developing the HFG strategy together, '*we spent the whole day in a boardroom. In the morning we looked at the ideas we had collected over the previous year and talked about them, drew pictures and shaped the vision. In the afternoon, the deputy chief executive of the local hospital trust helped us put our ideas into a plan – someone even helped us to bring it all together on a laptop! It was a non-stop day and it culminated in the chief executive of the Primary Care Trust listening to the fully formed plan'* (NDC Annual General Report, 2002).

The CHAP group had evolved organically as a consequence of the NDC launch and HAZ's steering. It involved local residents who wanted to be involved in planning health services. By 2004, it was a legally incorporated body of local residents who acted as a not-for-profit company limited by guarantee. Four of the community respondents interviewed in this research were involved in the CHAP group; respondent Keith was the chair, Kate was the company secretary, and Ann was the first treasurer until she handed over to Brian. The 2004 report commissioned by the NDC records the success of the model which demonstrated many local people participating in planning as a

result of the CHAP group.

'*They've accomplished 1000+ residents getting involved with the health programme … If you talk to any other within the city, they struggled to engage with the community. CHAP was successful via our Can Do projects'* (Prashar, 2004: 11).

The Clinical Advisory Group (CAG) membership consisted of statutory and voluntary sector workers working around health and social care who first came together in June 2000 at a HAZ scoping event. This participatory, open-space event was aimed at informing the front-line workforce about the Pathfinder bid and the possibility of the NDC being awarded to Wassail and Boothtown. As time went on, the members of the clinical advisory group (CAG) and CHAP groups came together collectively within the Health Focus Group, which met monthly to inform the NDC Partnership Board.

'*From the outset, we formed a group of local people who typically lived with long-term conditions and wanted to come together for mutual support. We became the community consultation element of the Health Focus Group, working closely with local health professionals who became real friends*.' (Keith: 269-274)

As CHAP began to gain confidence, assimilated learning and developed, we then began experimenting and introducing new ways of working across health and social care partners to encourage greater effective participation within the NDC agenda. By 2003, nineteen action-learning groups had been established linked to the HFG NDC work. Within my joint objectives as the Health Development Manager between 2002 – 2004, my first, key, overall objective was to:

'*Develop a framework for assessing need and address health inequalities and the evidence-base' as a specific objective 1. Develop baseline data, which demonstrates working with front line staff /local communities in partnership with PCT/LA the partners.*' (Professional Development Review, Internal HR document Renshaw, 2001).

In July 2001, at a Health Focus Group meeting, I began sharing the public health datasets with the local community. This included datasets around standardised mortality for the city wards. After the meeting closed, I left the datasets with the CHAP chair, Keith. When I returned two weeks later for our next meeting, Keith had analysed and disaggregated the specific health data as it pertained to respiratory, cardiovascular accident and cancer SMRs for the Wassail and Boothtown population,

ready to enhance the debate with the local residents attending the next health focus group meeting. This was very powerful. Keith had successfully shifted the capacity and power for understanding and learning from statistical health data. Then he successfully shared the learning within the wider community to help deepen and move the discussion for the whole of the group, enabling them to have an informed say on their health services. This was a seminal meeting for me, as it resulted in increased confidence and the community grasping a specific understanding of disaggregating data and its analysis as it related to specific conditions of heart disease, cancer and asthma and mortality in their location:

'*The community led the health focus group programme and identified what health services there were currently and identified what they wanted… The PCT was committed to working in partnership with CHAP in the delivery of first-class services*.' (Prashar, 2004).

The local communities' capacity to participate in the HFG NDC agenda was not about intellect, but facilitation by effective leadership, honest communication, and by supporting the translation of documents into appropriate formats to enable learning with trust, transparency and sharing across all partners. This complex dynamic was the beginning of the integrated working. The Joint Community & Public Health Needs Assessment paper highlights this and in 2001 it informed the NDC ten-year Delivery Plan.

These new engagement strategies continued to evolve organically across the clinical front-line workers and the local community members. As the activity increased, the trust and relationships blossomed as people got to know one another and began regularly attending the joint health focus groups.

7.6: Community involvement and models of change

7.6.1: '*Can Do*' Projects

The '*Can Do*' projects were introduced by the CHAP group into the NDC health programme to help the local community become involved in a variety of ways in the delivery of services. The diversity of projects identified by local people was translated into a series of small health projects, financed by NDC and facilitated and managed by the local people in 2001. The '*Can Do'* projects successfully engaged with people

in an imaginative fashion, in contrast to other regeneration projects which had huge difficulties with community engagement.

Particularly striking is the variety of the '*Can Do'* projects that local people opted to facilitate. These ranged from complementary therapy sessions, a sugar-free group, knitting for refugees and asylum seekers, exercise classes for children, baby massage, swimming classes for older people, sculpture, and head lice control.

Ann was the first treasurer of CHAP during the time that the '*Can Do'* projects were introduced. A very honest and accomplished bookkeeper; when NDC Partnership Board expressed misgivings about allocating £20K for twenty £1,000 'Can Do' projects for the community to manage, Ann's financial management, as the CHAP treasurer, proved them wrong. Ann managed the budget down to the last penny, which included aspects such as ensuring that people used second-class rather than first-class postage stamps! The transcripts' analysis explored the community respondents' energy and excitement for getting people out of their houses on dark evenings to discuss, sometimes at length, what they wanted in the small and activity-based '*Can Do*' health projects.

7.6.2: Clinical community and complementary health centres

Working together, the community respondents decided the location of the new health sites and the contents of the health facilities as part of a joint process with the front-line clinicians and the local community. They had identified the gaps in service and offered proposals to meet the neighbourhood's health needs. Kate mentioned the joint meeting with Triangle Architects, where the operational front-line staff together with the local community had begun to realise what the local community wanted in their clinical complementary and community health facilities:

'*We (CHAP) inspired, didn't we? As a group - community governance of the health and well-being resource centres - not as a PCT group practice'*. (Kate: 85- 87)

All respondents mentioned the commitment and energy from the members of the local communities and that the active participation of the workforce had, by this time, cemented firm working relationships and friendships as the first draft plans for the facilities were submitted to the NDC partnership board for approval in 2002.

The data analysis reveals the initial community respondents' responses as the CHAP

and HFG began to explore the local population's health status and understand the factors that influenced health. In 2000, the CHAP plotted the standardised mortality rates in the two wards and compared them against the available health and well-being facilities in the NDC area. The respondent, Keith, documents how he led this work as the chair of the CHAP group, and documents what were the local communities' expectations. The HFG NDC 2000-2001 plans demonstrate a proposed new clinical, community and complementary model and an enhanced way of working with front-line workers and local people. All the respondents mentioned, by working together on this proposed new model, how they wanted the facilities to function and where the health facilities should be located in the area-based initiative. The analysis documents the importance of the strong relationships, trust and confidence that the front-line worker respondents and the local community respondents needed to have to enable this active participation.

'*It was very important consulting with the community and getting them involved, and also empowering them to take control of their lives'* (Kate: 92-24).

This increased engagement was not a subliminal, hidden process, but rather it was a very transparent, active and debated process aimed at the front-line workers and the communities finding joint solutions to help improve the existing services.

7.6.3: Gain confidence and empower

Community respondent, Kate, mentioned how the local community had gained confidence as they got to know one another and actively made choices, identifying what they wanted and also making decisions related to resource allocation. In addition, she experienced rich learning, working together with the local clinical professionals currently delivering the health services in the NDC area.

Kate grew up in Wassail and Boothtown but, after a number of years, her husband, who was a builder, persuaded her to buy a property on the periphery of the area. She regretted moving out the heart of the regeneration neighbourhood, she missed the local people and was very passionate about supporting the regeneration programme and making a difference. She wanted to establish a common ground and help all partners to be involved:

'*I think I was living in a [different] world in the early days and working [so hard for] this*

community engagement with the statutory sector. More than ever, I was wanting a common ground and also to be in a position to make a difference.' (Kate: 52–55)

She saw herself as '*playing a part and trying to bring it all together. But I was only a small part of it - I did have commitment, did have passion about it*…..' (Kate: 58–61)

She acknowledged the importance of all participating: '*It was consulting with the community and getting them to become involved, and also empowering them to take control of their own lives. Well, at the time, when we first set off, we did have the support in place. We had the Health Development Manager, we had the Health Programme Manager, and we had all the relatively important people on board.*' (Kate: 97-101)

7.7: The respondent's experiences of the new structures for participation

7.7.1: Employment in the participatory agenda within NDC

Rose was a vibrant, vocal 19-year-old teenager when she became one of the three local people who took on a paid position in July 2000 within NDC as a community animator. She describes becoming involved in the community animator's outreach work, asking people their views on what they wanted in all the public spaces, using large and small events to collect qualitative data across as many as possible of the 10,000 people living in the area. Rose describes how she got involved: '*because I thought it was going to be different, an initiative to make things better for the local people and give people a voice*' (Rose: 44–46).

Rose first became involved in 1998 when she was living in the Wassail ward with her mother, when she joined the data-collecting team and was employed to collect views and develop a coherent understanding of what the local people wanted in order for it to be included in the NDC plan.

One of the respondents, Sally, mentioned she had lived at the current address within the patch for over twenty years and was well-known as a supportive neighbour, generous and helpful with her time and had had employment as an assistant within the local shop. Sally had an ability to connect community members, and facilitate pathways and this successful networking supported self-generated, internal solutions. Data analysis shows she lived in Wassail and, at the time of the questionnaire data collection, she was a carer support worker employed through CHAP, working closely

with Rose out of the newly built Sunrise Centre at St Stephen's. When asked what she thought she achieved being involved in the regeneration programme, Sally commented it was about using her influencing skills in the early days of the NDC programme.

'*At first - it was quite exciting - because I'd worked with the community for about seventeen years - doing different issues, helping them with different things, getting things done! Influencing the councillors. Trying to change the way people worked. Involving community. And so a couple of years on when a job came up in community involvement in the New Deal for Communities, which I think the title was then 'Participatory Appraisal Worker', myself and other people got the job - we were to go out and ask people what they felt about the area. What they would like to see changed? About the money coming into the area for the regeneration which was £53 million!*' (Sally: 59-75).

Employed as a community animator within the NDC, Sally identified the importance of listening to people and involving people so that their views were taken on board to make a change in the area.

'*Well I thought they would, that they (the NDC Partnership Board) would actually listen to what evidence we came back from the community with. (And) take it on board. Instead of just, you know perhaps ticking boxes and yes saying 'YES'. We have got so many people involved, and they (the local council) were just doing it… to just like tick a box ….we'd actually like to make a difference. For them to listen to us - work alongside us really, and to see a lot of change in the area'* (Sally: 92-101).

7.7.2: New health models involving the community

In 2000, both the clinical and the community actors began developing action-learning sets using the cyclical model of participatory involvement together; planning, acting, observing and reflecting, with the emphasis on specific health activities that the health focus group members wanted to collaborate on (Lewin, 1946). The action-learning sets encouraged reflective practice at the onset of the process as the health focus group actors began working together. This approach was beneficial as it enabled small groups of people to communicate and collectively share their perspective. This approach also allowed the actors to reach a consensus agreement and then organically evolve into the next stage of the health focus group, the NDC planning

process. The research data identifies that from 1999, when the city first began developing the Wassail and Boothtown bid for the Pathfinder status and in 2000/1 implementing the NDC programme, the health focus group and the clinical, advisory group (CAG) membership numbered forty-five. The number of local people actively involved in the NDC health focus group was consistently around forty, throughout the period 2000-2004. It was supported by the Social Action Research Project (SARP) as a model of participatory change. By using reflective action-learning techniques, the NDC health focus group programme helped ensure that the community learning was captured and sustained (SARP, 2003). I submitted a successful bid to the NDC board in late 2002 and, in early 2003, the action-learning research was funded as a three-year HFG NDC research project with the first open introductory meeting (23rd June, 2003) held in a community space in Boothtown Activity Centre. Thirty people attended the open, introductory meeting and became involved in the action-learning sets. This group included two of the community respondents, Brian and Keith, and two of the workforce respondents, Jo and Joan, interviewed in this research.

The Social Action Research project findings (SARP, 2003) and the NDC delivery plan in June 2003 showed that community involvement requires participatory learning styles. We formalised the action-learning process and applied for NDC monies to work with the local university to help protect, sustain and develop these new community learning spaces (NDC Bid 2003).

7.7.3: Emerging community governance models

The community respondents' data analysis explores what key elements were needed to initially encourage and support both them and others in their local community to become involved and, then, what helped sustain that involvement. The community respondents all repeatedly mentioned they wanted to be involved in delivering their own health solutions. Members of the community represented in the research became the core focus group and key members represented the local community on the various NDC health focus groups. Using action-learning sets, they recorded their experiences about working directly alongside the health and social care workforce.

This data analysis reveals that the parallel process, which the front-line workforce was initially involved with in their own separate clinical advisory group (CAG), was a key to the deepening community governance model in the NDC area, as documented in the

CAG minutes:

'*A partnership of agencies has worked strategically and operationally together in City LK&C over the last three years. We have developed a health settings based approach to the neighbourhood renewal agenda that demonstrates a new way of tackling inequality and achieving health gain. Together with residents of the area, statutory, voluntary and private sector partners are now on target to implement a new innovative community health action system! Central to achieving these results is the development of the community health action partnership (CHAP), a resident led collective, who have already developed into a registered company. CHAP will direct and support the empowerment of local people and be key in all the decision-making processes*.' (Wassail and Boothtown: HFG minutes, 07.11.2002)

In 2000, the local community had begun evolving into the first, core group of actors that went on to become the CHAP community interest company. As an insider, I was in a unique central position within the developing NDC delivery, and early in the programme I felt I needed protected reflective time to explore and understand the evolving complex environment. It was at this point, in 2000/1, that I enrolled at Salford University, specifically in the Revans Institute where I became part of my own action-learning set. This gave me an opportunity to learn the techniques of reflection and action and how to facilitate an action-learning set, as discussed in Chapter 5. The delivery of the NDC programme gave me an opportunity to both interview the respondents and collect and analyse the transcripts and the wider data. Keith and Brian began volunteering directly within the Health Action Zone, which, in autumn 1999, had chosen Wassail and Boothtown as a development site to pioneer locally a new way of working. I first met them in my role of the Health Development manager, and we initially met off-site, in an office based environment:

'*Do you remember the first bits when we used to come over to HAZ? Yeah that was enlightening, yes…. The discussions we had… The problems'* (Brian: 41–45)

These two respondents began the very early exploration and development of participatory, community-engagement models in order to bring together key stakeholders, to involve all those contributing to the health of the local population and to work with those partners to develop plans and agreed-upon local strategies for improving the health of the local population (HAZ, 2001).

My role within the HAZs enabled me to act as a facilitator supporting interagency cooperation and inviting individuals to meet together to help identify some of the key, emerging health issues. The city had, prior to this, a strong community consultation infrastructure which Keith and Brian already had experience with. They had both been involved in the adjoining area's Single Regeneration Budget redevelopment programme's public consultation exercises. Keith discussed how these consultation involvement exercises, in his opinion, had not resulted in the tangible outcomes that the community had stipulated they wanted. I was aware and sensitive to this previous history when I met with these respondents a number of times outside the NDC area, before I went into their community spaces to work with them on the development of the NDC Pathfinder status. These two respondents were central figures within the community and, as connected community members, it was from this privileged position that Keith and Brian introduced me into the local area in 2000. This '*snowballing*' introduced me to incrementally greater numbers of the community and was key to driving the participant agenda to raise awareness and engage people in the programme.

My role and relationships across community activities helped disseminate the participatory and social-cohesion models learnt from the city SARP (2003) research programme within the developing NDC from 1999-2003. The data suggests that conversations about active engagement in communities were beginning to become debates within the smaller, health working groups.

In this initial phase of the programme, people began to have confidence that their views and opinions were valued and they would be listened to. We built on principles of respect, trust and clear communication and local understanding and, believing that they would be listened to, clusters of people began attending a variety of events and open-space consultation.

The NDC launch event in March 2000 was an interactive event attended by over 400 local people where people's views on key issues such as crime, health and unemployment were sought. Together with a small, core group of people, we had devised this interactive '*game*' using monopoly money, large flipcharts, lots of sticky notelets and felt pens. Talking on a one-to-one basis, we asked people how they would spend local 'new NDC' money on health. This interactive process generated a lot of

interest and also contributed to the first NDC health plan. One of these respondents, Keith, was also on the NDC Partnership Board, representing local people. In addition, he was also the second chair steering the CHAP in the very early days of its development. A massive asset representing the community, he was still contributing in 2008 and also involved in volunteering within the NDC programme and became involved on a national, entrepreneur programme.

7.7.4: Participatory processes raising health awareness and outcomes

Analysis of the CHAP minutes and additional data documents revealed that the first chair of CHAP, prior to respondent Keith taking this role, was a local resident who had had a heart attack and resigned. This first chair of CHAP had been having chest pain and angina and heart attacks in the previous few years. This was prior to his involvement in the NDC and when Wassail and Boothtown was poorly serviced by primary care facilities. However, his understanding of his health needs was acutely enhanced by his short involvement in the NDC health programme. After his latest cardiovascular angina attack, because of his increased knowledge, for the first time he successfully lobbied his GP and subsequently received appropriate, acute, hospital care and was referred for a coronary artery heart bypass.

Respondent Kate was passionate about the regeneration health programme and became involved in a wide range of different roles. These included supporting the formation of some of the key groups within the statutory sector. This respondent mentions being on the PCT/LIFT group in 2003 as a community representative when the first discussions took place regarding the finance initiatives, including the Local Implementation Finance Trust (LIFT 2001). She discussed the changes in the health and social care agenda with the new policies New Labour began introducing from wider departments than the ODPM.

Respondent Kate identified that she felt she understood the complex group dynamics and wanted to continue her active involvement in supporting the agenda from a community perspective. Her transcript demonstrates clear, analytical, logical thinking and identifies her role as generally the minute-taker responsible for the administration, someone who would volunteer to take the notes. Kate suggests she initially became involved in '*everything!'*

'I got involved in everything! Every committee going didn't I? I was on everybody's

steering group. I was like rent-a-crowd I was; I was ticking the boxes for the more… Yes I was involved in the primary care, the PMS steering group, the horizon steering group, the steering group of the health centres.' (Kate: 226–229)

Her transcript documents chronologically the growth of CHAP's members' confidence and knowledge as they explored the local health needs. The transcript itemises and gives examples of the alternative ways of delivering health that she was involved in, including when the CHAP group went to London to see the Bromley by Bow project (discussed in Chapter 3). She describes how the HFG participants were closely involved with the Triangle Architects, working together within the community spaces to actively and jointly design the clinical, complementary, community health facilities, painstakingly drafting and redrafting expensive architects' plans to get them right to ensure that the specifications met their needs first, before they submitted them to the PCT/LA in 2002. The analysis of Kate's transcript gives an insight into the importance of the participatory '*learning and sharing events'*, workshops and celebration days, which she believed helped increase the community capacity and knowledge throughout the whole development of the health process.

'*We (CHAP and HFG) aspired, didn't we? As a local group to be leading the community governance on the development of the health and well-being resource centres, us not the PCT. Health and well-being in the widest public sense. It really gave people the feel-good factor as far as exercise, nutrition and complementary therapies. It was consulting with the community getting more involved, and also empowering people to take control of their own lives. You know part of getting the community to take some chances. I firmly believe in and I still think it could be achievable*.' (Kate: 85–97)

One of the respondents, Seren, first became involved in the NDC in March 2001 when she took up the full-time, NDC Office Manager post. She left this NDC position in 2003 to start her student nursing. The data identifies she *'wanted to see a change in the area; I grew up here, I just wanted to see it go back to how it was, when I grew up here.*' (Seren: 80–82). Her data transcripts highlight that she was privy to all of the NDC meetings internally and understood the complex dynamics, the politics of the different actors and the wide variety of groups and the decision-making processes. Interestingly, Seren described how her involvement as a volunteer within the HFG had been the catalyst for her interest in working directly in the NHS and, as a result, she

applied successfully and undertook two years training as a nurse in the city. Throughout 2001-2007, this respondent continued to be employed part-time in the NDC.

Two of the respondents, Noreen and Brian, had been married for over a decade at the time of the bid for the Pathfinder status, having moved to the city from a small village in Wales. At one of the first open-space events, Noreen attended with profound mobility issues which had necessitated her using a wheelchair. However, this did not deter her from committed involvement, actively instigating some unique peer-support work related to diabetes throughout the following five years. Noreen came to the health stall at the NDC launch event in 2000 and began, on an individual basis, discussing her own personal health needs. From this point on, she regularly attended meetings and contributed to the wider health plan. Noreen identified areas where she was passionate about improving health provision from her own personal experiences and it was on these topics that she led, for example, diabetes. Additionally, she also offered herself as one of the first volunteers locally to attend innovative peer-led training as a tutor, facilitating courses for people with long-term, limiting conditions.

Noreen had had scant schooling, having left home early as a teenager when she had become pregnant as a result of abuse by her father. As a consequence, she had poor literacy levels; however, she was a particularly articulate, kind and sensitive individual. Brian and Noreen attended the first, national, Expert Patient Programme (EPP) training in Birmingham and this was almost a completely disastrous experience for their self-esteem and confidence levels. Ironically, exactly what the programme was supposed to support within its participants. Brian and Noreen gave up their time and went to this training voluntarily; however, the group was made up of upper-middle-class retired professionals and the core tutors from London '*failed*' them at their final assessment. This was redressed sensitively, supporting her to build confidence when they returned to the city and they had the opportunity to revisit the training programme with one of the workforce respondents, Jo, who was also working on the Expert Patient Programme.

7.8: The opportunities in the reconfigured PCT

Between 2001- 2002, the new, senior strategic directors were appointed into post to work within the reconfigured health sector. The data highlights, in both the workforce

respondents' and local community respondents' analysis, that by the time the PCT was constituted, the NDC Health Focus Group and CHAP had formed a group and successfully completed their first eighteen months' work.

'*And the people I met and the friends I made and belonging – because we all felt, we seemed to gel as a whole. Because we had one thing in common, we wanted the same thing*.' (Kate: 114 – 116)

Throughout her transcript, prior to the health sector changes in the new PCT, Kate suggests that communication, trust and the importance of the relationships they made had helped improve connectivity. She mentions it was working together, co-producing the work, that helped the HFG early in the NDC programme. This respondent identified initially, when the PCT was just formed and the people were coming along to the NDC health focus group and they wanted to be friends with the community, that there was a greater shared vision and a common purpose across the community, workforce and NDC statutory sector working together.

'*Round about that time, that was when the PCT was forming and lots of people within the PCT were dropping into positions, and people were coming along wanted to become friends with the community. They all want friendship with us*.' (Kate: 119–121)

She suggested in her transcript that she considered that the participatory health agenda was a means for the new incoming staff to secure better jobs in the reconfigured PCT, and they then behaved as if they did not need the community.

'*Now looking back, it was all, well I feel, they were all jumping on this ladder of careers and they all got new positions in the PCT, and as they got the new positions they moved away. They moved outside the circle. And then they all moved on and didn't want to know the community after that, however we were in it for the long haul of the community. They were just in it for the short term and just to get on'* (Kate: 122 – 128).

7.9: Participation in local health planning

To enhance a systematic approach to the data collection, I had adapted the same questionnaire across the three different cohorts interviewed, in order to help identify links and strengthen accuracy. The community respondents' data analysis identified that all wanted new health and well-being resources in the area. The data analysis also identified the wide discussions that took place in the CHAP and HFG spaces in

the first two years of the NDC programme and how the local actors arrived at a consensus on the way that the new NDC resources should be designed and delivered.

7.9.1: New models of community involvement

From my position within the HAZ, I helped the formation of the local area groups in 2000. By 2001, I had established structures with timetables circulated and meetings with agendas and minutes. This was to help improve communication between all of the different actors from community, local government, health and well-being and more distant partners within the area-based initiative.

7.10: The impact of the introduction of the policy changes

The analysis of both the local people and the front-line workers' data, however, also indicates that when the PCT introduced financial-policy decisions which emanated from the central government's Treasury department, that these new, financial policies disrupted the established, community-engagement process and damaged the existing relationships. These policies included the local-implementation, finance trust and public-private, finance initiatives together with the new strategic actors and were introduced late into the NDC process.

'*Then they moved (the consultation on work) outside the circle! Lisa Clover (pseudonym of CAG member) who was working with us, but then Lisa became ill*' (Kate: 130-132).

The introduction of New Labour's Treasury Department public-private, finance-initiatives policies is discussed further in Chapter 4. Two of the community respondent's transcripts mention their first introduction to the PPFI policy as the Local Improvement Finance Trust (LIFT) project, which was proposing to finance NHS estates across the city, including the NDC location. The Primary Care Trust raised the subject as a financial mechanism to introduce additional resources which would improve existing primary care states and empower the staff through a better working environment (LIFT, 2001). One community respondents' analysis suggests that the community was consulted on the introduction of the new, public-private finance introduced into the NDC health focus group work. In her role specifically as secretary of the CHAP group, Kate refers to the need for the communities' approval in the joint finance initiatives related to securing capital for the NDC health buildings.

'The local implementation finance trust was introduced across the city and NDC was encouraged to work with LIFT too, and NDC got involved didn't it? The LIFT Company consulted however, I think we were manipulated as a group then. We were used as a consultation tool really. By Nicky Kelly [Pseudonym - PCT Director facilitating LIFT project], in the absence of the Health Development Manager. She used that situation to manipulate the group, with HFG and CHAP being the consenting tool used about LIFT, getting involved in Wassail and what she did with the group! She divided the group to conquer it.' (Kate: 140-151)

Kevin's data suggests how the community felt about the engagement of the tactical and strategic actors within the emerging and established working groups by 2003.

'*We did a great deal of work deciding what kind of health facilities we wanted in the area with a great deal of community consultation. We wanted two Community Health Resource Centres. One attached to a voluntary community centre specialising in work with the elderly which would focus on services for the elderly. The other to be attached to a voluntary centre in part of a school, with a focus on youth; NDC were to pay for the build. There would be no doctors. They would be person focused*.' (Keith: 278-287)

The community respondents discussed the happy times they had experienced in the first few years of working in co-production and partnership and the data records that things began to disintegrate in mid-2003 and early 2004. Maria identifies that these changes were because of the PCT becoming more involved within the NDC and wanting more control and that this then resulted in the community having a reduced stake and a knock-on effect on the local ownership of the health facilities.

'*To me it started falling apart when they started fetching in professionals, that's when it started falling apart. Because they, they didn't live in the community.'* (Brian: 270-274)

All of the respondents experienced sadness and regret as well as no longer feeling as if they were part of the decision-making process in the NDC. This left a very bitter taste in the community's mouth, as they lost any decision-making control. Noreen graphically describes: *'we were just used as puppets; we weren't even told we weren't wanted*.' (Noreen: 250 -251). They also commented on changes as strategic leadership changed. Following the retirement of Ms. Higgins in 2004, her supportive

patronage for the health development work ceased abruptly and the PCT senior management changed.

Sadly, Brian thinks that, after eight years, they had only been part of an experiment. '*We were used as guinea pigs because it was a big experiment they were trying out*.' (Brian: 252-254)

Noreen and Brian had spent hours volunteering, participating in a whole range of different aspects of the health agenda and the young people's programme. My analysis of Brian's responses reveals an insight into certain actors' reluctance to share knowledge and communicate with the community, which was necessary for the community taking more control and power.

'*And too many people who had knowledge but didn't know how to use it. And too many people who had power (in LA, PCT) without knowledge - you understand me? They have the chance to teach the community, about sorting things out, about being able to start off businesses and everything*.' (Brian: 263 – 269)

7.11: CHAP Chair making executive decisions with the PCT

The data transcripts identify that a number of the community respondents had tried to make sense of why the CHAP were no longer being included in decision-making or consulted directly on the requirements and personnel to be included in the health centres. Changes in the dynamic of the joint PCT / CHAP / HFG decision-making processes were discussed in the community respondents' questionnaires. In late 2003, the Chair of the CHAP group changed when the membership voted and elected a young 26-year-old, single mum who lived in Boothtown. In the summer of 2003, she was invited by herself without the knowledge of the whole, community health action-partnership group to attend a number of decision-making meetings within the PCT offices by Rosa Lea [pseudonym], PCT Director responsible for community governance, together with other members of the statutory sector. The rest of the community received neither the minutes nor any briefing from the new CHAP Chair about these discussions or the decisions made on their behalf. Some of these were financial agreements specifically to enable CHAP, on behalf of the community, to sign up to the newly introduced, public-private-finance initiatives involving the health estates across the city, which had introduced the local implementation, finance trust (LIFT) proposals in 2003. This would then effectively ensure that the half a million

pounds that the health focus group had already secured from NDC and Government Office NW, which had been allocated for the new health facilities, could be transferred into the LIFT/PCT budget.

'*I first I think Hilda ([pseudonym] second chair of the CHAP group) got a little bit big headed. She's all right - everybody's entitled to make a few mistakes and I think she made quite a few didn't she? Because she didn't come back to the board, tell us what was happening and I think that's what did it with her.*' (Brian: 298–305)

It was not until 2004, when the first full CHAP meeting was held, that these issues were discussed for the first time at a full group. This was a painful and stormy meeting, but, as it was a closed community meeting, the PCT Director responsible for community governance, Rosa Lea and I waited outside for the outcomes. Hilda Roberts, the CHAP chair, resigned at this meeting. Noreen commented that this resignation was necessary as, throughout the summer of 2003 and with the support of the new PCT director for community governance, *'she was making decisions without involving the board.'* (Noreen: 306-307)

It was at the 2004 meeting that the CHAP board then immediately elected another Chair, Doris Smith ([pseudonym] third CHAP Chair), who continued as Chair until 2007.

'*Yeah she didn't like it when she got pulled up over it, and all right Doris took over, I think she was talked into it, by Antony and Bernard* [*pseudonym*]*'* (Brian: 308-310)

Respondent Kate's transcript commented on the night of the CHAP board meeting and that she learned that Paula, Antony and Bernard [pseudonyms] had been coaching and supporting Hilda the CHAP Chair over the previous months, '*to enable her, as community representative, to make decisions in PCT meetings on behalf of her neighbourhood and CHAP. Were we naive? When I look back, we were so naive!*' (Kate:188–189).

As a new chair of CHAP, Hilda had, until that point, no previous board experience or understanding of decision-making within the Primary Care Trust. Respondent Kate and half of the community respondents' transcripts made reference to the changing relationship between CHAP and PCT in 2003: *'It also appears to have been from the time point when joint decision-making was retracted back into PCT' (Kate: 103-104).*

My research analysis identified crosscutting themes, which require further in-depth analysis, with the potential for manipulation of individuals as '*representatives*' or of the local community, as seen with the political manipulation of the CHAP chair.

7.12: Impact of managerial changes on HFG and CHAP NDC

Shortly after this board meeting, in March 2004, the PCT Chief Executive Edna Robinson retired and, within the week, my Health Development Manager role ceased.

'*During the spring/summer of 2004, the NDC Health Development Manager was removed from post. This occurred at a crucial period in the life of this piece of research, when the methodology was being explored in greater depth by both researcher and the Health Development Manager. The absence of the health development lead and the decision not to appoint a replacement Health Development Manager meant that the health focus group work then lacked valuable guidance*.' (Prashar, 2004)

Kate's data suggests that the model of community governance that had been developed by the health focus group and CHAP was found unsuitable by the PCT. In addition, the community governance model which the community had decided upon made it difficult for the PCT to make executive decisions about the health estates.

'*When you think about the people who want to be part of, in them early days - and then <u>they all moved on</u>. They didn't want to know the community after that. But then we, we were in it for the long haul - the community. They (strategic senior managers) were just using it for a short step - and it was just to make sure they got on, because that, also at the same time that happened, (local implementation finance trust) LIFT got involved in the health estates in NDC. The LIFT Company. I think we were manipulated as a group by them (LIFT Group). We were used as a <u>consultation tool</u> really. By Nicky Kelly in the absence of the Health Development Manager*.' (Kate: 132–144)

The community respondents' transcripts clearly outline how, after the initial partnership working and joint involvement in planning approximately up until 2002, any working in partnership with the community, particularly from the position of the PCT, diminished. As the Chair of the CHAP group commented in 2002:

'*In my opinion, governance and community representation are absolutely critical to any group activity involving public finance*.' (Keith: 599-601). However, the transcripts

all suggest that the community did not feel as incorporated or involved in the new PCT partnership working or the LIFT discussions. '*I personally feel the community has been pushed to one side, and I think it's been used just* 'tick boxes' *of the NDC organisation.'* (Sally: 157–161)

The PCT secured financial arrangements with central government and the Treasury Department, which introduced the LIFT Company into Wassail and Boothtown. The PCT and the LIFT Company then financed and owned the 25-year mortgage on the two new health centres in the NDC area. This public-private-finance initiative, introduced into the NDC area, effectively moved the realisation of the wishes of the community regarding the health facilities into a secondary position and the community were unable to secure sufficient resources to rent space in the new health buildings. Whilst the financing was a critical aspect of the NDC programme, the complex management of the relationships and an integrated approach across all of the partnerships were needed for the realisation of the programmes. The in-depth analysis and interviews undertaken by Prashar (2004) highlighted this aspect: celebrating CHAP's achievements and successful community engagement work, especially considering '*the many organisational stakeholders from various projects and particularly given the complexity of the relationships between the PCT and NDC, and CHAP's initial lack of experience in developing relationships and services for the local community*.' (Prashar, 2004).

However, one respondent highlighted that the community had lost all its involvement and management in one of the new NDC health buildings when it was finished: '*Well what happened, Boothtown building, the first one to be built, and that's now called the Energise Centre where I'm based. But the actual community involvement I think has been taken away from my company, CHAP.''* (Sally: 150–156)

Originally, the community had extensive plans to involve community groups to operate from the new centres; however, they were unable to resource the rent to allow them to become tenants in their community building. Sally's transcript analysis revealed that, after the buildings had been completed, the community did not use them:

'[*The] buildings are very underused because they didn't listen to what people wanted in them'* (Sally: 169-171)

Data analysis of the community respondents' questionnaires reveals that the majority

understood that the need to resource financially the new facilities had taken precedence over the agreed community governance model. The data described '*local people getting tired with the senior managers from the PCT and the LIFT Company withdrawing and the local people that had been involved from the beginning getting worn out*' (Sally: 161-163). The community began to lose interest.

The members of CHAP and wider HFG began to lose energy and the impetus to persist in order to try and get what they wanted included in the NDC health plan declined. Also, they had had a fresh insight into the decision-making process in the NDC and, after a protracted period of involvement, it appeared that they were not being listened to.

'*Obviously getting the building, people worked hard for seven years and achieved getting the buildings. Yeah. However, I don't believe we've got the right GP in them and I don't think PCT are taking notice of what people wanted, and they are making decisions and changing things. But they're not actually listening as to what people actually put down.*' (Sally: 256-264).

In 2007, Keith's data showed that he had moved on to become very involved with the regeneration of the physical environment within NDC and was a member of the Physical and Environmental Focus Group. However, he was still involved in the NDC health agenda too. His transcript highlights his insight into the dynamics around the demolition of local people's houses, the factories and local schools and how the local council was encouraging people to accept NDC grants in order to enable the local authority to compulsorily purchase the land.

'*In the area that covers what was Northern Fields, Rockall... and the park and what was the High school that's been demolished and along far as Boothtown Riverside… Mainly demolished.*' (Keith: 34-36)

For the first six years of the programme, Noreen and Brian lived in Boothtown in a council property. At the time of the data collection for the respondent interviews, Brian and Noreen had requested to be rehoused as a result of being disillusioned with the outcomes of their involvement in the regeneration project and had moved out of the NDC area into Little Hulcaster. The data discusses the antagonism and feedback they got from their neighbours and local community.

'*We got hell [from our neighbours] towards the end because they knew we were working on the community project. ''You promised us this, you promised us that, where the bloody hell is it!'' You know it was us that had to put up with that, not people like CD, (manager employed from out of the area CEO CHAP). He didn't live in the community, he didn't have to put up with it. Getting threatened with getting your windows smashed because you couldn't get things done for them. We were getting shit put through our front door and everything*.' (Noreen: 806-817)

One of the front-line workers' respondent transcripts in their role as NDC Deputy Coordinator, managing the human resource issues discusses helping with the damaged working relationships and the redevelopment of trust and volunteers who had taken up paid employment in NDC to make the transition and be able to contribute in the culture of the city council. The data identifies tensions that needed to be accommodated when employing local people within the local authority culture. Alice, one of the front line workers who was working with and employing people from the local community, discusses managing and supporting their transition to employment and yet maintaining the identity of the local community members. This is mentioned from the local community respondent's perspective:

'*When I worked for the New Deal, they (NDC) didn't like me living on Wassail Lane. I don't know what happened with it, they (local authority) just didn't like, and I moved out. Because I wasn't allowed to join any of the residents' groups or anything.*' (Rose: 8-12).

Rose's transcript and interview in 2007 highlighted that she was dissatisfied with the outcomes of the NDC regeneration programme and what they had actually achieved.

'*Originally I was employed as a community animator with the new deal for communities in 2000. Consulting local people and giving aspiration to a new government initiative was going to change their lives. And it didn't.*' (Rose: 62–67).

7.13: Conclusion

Whilst the NDC programme did increase participation of local actors in decisions that affected their lives, the research data analysis indicates that was for a few rather than the whole community and it was time-limited with political manipulation using professional-led power. The initial involvement did result in a few local people applying

for statutory and voluntary roles and challenging the working environment and culture of both health and local authority service provision.

'*The aim of introducing NDC programmes was initially to ensure greater stakeholder involvement and increased contribution of greater community participation in service delivery.' (NDC Delivery Plan, 2001)*

Analysis of the community respondent's transcripts and data demonstrated what a major supportive role they thought the strategic players had between 1999/2003 in helping develop the local participatory agenda. The community respondents identified clearly in the data that the strategic actors had a major impact on the operational front-line staff and also helped facilitate their ability to actively participate and influence the development of health and well-being facilities, and to affect the development of the community health projects in the NDC area. Both the regeneration policies and the new workforce legislation introduced a shift in the balance of power towards another domain. The data confirms that participatory engagement allowed, at least for a number of years, constructive partnerships to flourish. These then declined.

The data suggests that an emerging role of the HFG and CHAP was to represent accurately what the local population wanted within the NDC health programme. The respondents mention that if the people are asked what they want and then their wishes are ignored, the developing trust is damaged and participation or involvement of the local actors in the design process is lost. A high trust culture is important for joint participatory working.

The community respondents identified that the strategic actors' priorities appear to have changed in late 2003 with the introduction of the PFI policy. The impact of the supportive, earlier strategic actors leaving the NDC highlighted that there was an increasing precedent to shift the focus to meet the financial drivers, resulting in central government moving away from the community participation agenda. These strategic policy changes within central government directly impacted operationally in the area-based initiative and shifted the involvement away from local people and front-line workers. Across the longitudinal timeframe, the data analysis demonstrates that finances took precedent over participation and the introduction of PFI's from central government policy influenced and helped to deconstruct the established, operational joint participatory working within the local neighbourhood.

The key themes highlighted from the community respondents' analysis are discussed further in Chapter 9.

8: Participation in the NDC - Wassail and Boothtown: An Analysis of the Strategic Respondents' Views

8.1: Structure of the data analysis

This final analysis chapter is based on a series of interviews with three strategic respondents. The health and social-care, strategic environment was changing to meet the new requirements and deal with the impact of implementing the multiple, central government policies and legislative changes that New Labour introduced when it came into power in 1997. These health and social-care reconfigurations are discussed in Chapters 3 and 4. The three strategic respondents interviewed introduce different perspectives to the research analysis in relation to their responsibility for implementing these central government health and social-care policies. All three respondents were involved in the regional, geographical area and working in the specific neighbourhood when the Pathfinder bid was being developed. They were also involved in supporting the tactical, strategic and operational elements of the wider, joint-policy initiatives introduced in 1998-99, as well as the ten-year NDC programme. The respondents' experiences occurred between 1998-2007, within the context of the central government introducing their NDC regeneration policy.

The strategic respondents' experiences and views are summarised in the text and expressed in quotes drawn from their interview transcripts. Using participatory observation and action-learning, reflective-practice research, I support the strategic respondents' data with additional, contemporaneous data drawn from journals, minutes, emails and papers. I explore the three strategic actors' perspectives as their lived experience with the introduction and implementation of central-government policy, concentrating, in particular, on how they experienced changes at a strategic and neighbourhood level within the health sector.

8.2: My role in NDC: strategic partners

As the insider researcher, in 1998-9 I was working in the Liverpool Health Authority as a Commissioning Manager when the New Labour government came into power. The Liverpool Health Improvement Programme (HImP) responded to the new government targets and identified the Health Action Zone as a focus for its joint activities and as a framework for implementing central government's health priorities. In the December 1999 Liverpool Health Improvement Plans HAZ update, central government schemes

began devolving into the Merseyside Health Action Zone:

'*It is clear that HAZ issues run right through this list. This means that HAZ is and can be legitimately linked to work on the priorities of the Secretary of State. Please remember to use this information when publishing HAZ work or applying for funding /support*.' (LHA HImP/HAZ, Update no. 10, 10.12.1999)

As one structural change, health and social-care bodies evolved and the Primary Care Groups (PCGs) were preparing to become ratified. It was at this point in 1999 when I began the negotiations to move to a secondment within the Manchester, Salford and Trafford Health Action Zone from the Liverpool Health Authority (LHA). An email between my line managers within the LHA clearly states the likely objectives for the proposed secondment:

'*Phil's objectives for the secondment have yet to be finally agreed with Frida Higgins (CEO MSAT HAZ) but they are likely to be: Development of Health Impact Indicators for Regeneration; Impact into health strategy for East Manchester; Comparing and contrasting the development of corporal government between The City Pathfinder and the implementation of New Deal for Communities in East Manchester'* (Memo from LD to TB, 9.11.1999).

It was while working in this seconded position within the Health Action Zone, and then latterly as a joint employee of LA/PCT as the Health Development Manager, that I had direct permission and gained my first-hand experience of the strategic, tactical and front-line workforce. Working across both the vertical and horizontal axes to achieve the set objectives, I began to develop impact assessment tools with these workforce colleagues to enable us, collectively, to measure the work and gain a wider understanding of the specific impact and outcomes of the area-based initiative.

This HAZ secondment position gave me a unique opportunity to be introduced and work alongside a variety of strategic actors across the region. It also allowed me to experience the insights that key strategic actors in the city had on enabling the new legislation to be implemented with the Wassail and Boothtown NDC Pathfinder. I was part of the cohort of people who introduced incremental, health and social-care changes to support the delivery of the NDC regeneration programme. My role not only gave me contact with a wide range of strategic actors, but also access to the central government agenda and the local regional agenda as they unfolded. The HAZs

collectively filtered centralist government policy directives to executive level within regional statutory and voluntary bodies. This necessitated my coming into contact with a wide range of strategic actors at multiple levels, including statutory and voluntary regional directors with responsibility, local councillors, Members of Parliament and the Prime Minister, government officers, and directors within the Primary Care Trust and the acute hospital trust. The Health Action Zones had been introduced and established by the New Labour government and had begun working directly to interface with the strategic, statutory sector partners to support the introduction of the new central government policies. The Office of the Deputy Prime Minister simultaneously introduced the first wave of the area-based initiatives with the responsibility to help develop solutions to the growing inequality across neighbourhoods. This longitudinal research commenced when there was a change of central government, after three terms of Conservative office, as New Labour began to introduce its Third Way policies.

The context for the data analysis is where the operational delivery of health, from the previous community trusts, was being reconfigured into the responsibility of the Primary Care Trusts. The City Local Authority also began to support the development of the Local Strategic Partnerships.

8.3: Key characteristics of the three strategic respondents

For the purposes of the analysis, I chose to concentrate on three strategic respondents whose combined perspective covers the regional voluntary sector, the central government's policy agenda and the new Primary Care Trust.

Table 8.1: The three strategic respondents

Pseudonym	**Some background information**	**Role in NDC**
1. Jenny	Liverpudlian, in her mid-40s, living in the nearby city and employed as an executive director in a large social enterprise within the North West Region. In 2001, she became directly involved in the strategic activity in Wassail and Boothtown NDC. On behalf of the voluntary sector, she also worked within the HAZ and, from 1999, was involved in	Executive director non-statutory, regional, social enterprise. She was involved with HFG & CHAP helping

Pseudonym	Some background information	Role in NDC
	supporting and setting up community enterprises. Jenny was a clinician / nurse in the health sector by profession who moved into LA regeneration as a community development worker prior to her role as a director in the voluntary sector charity.	them become a Community Interest Company.
2. Hayley	Hayley was the Labour Member of Parliament for the city. In 1997, she began working extensively with the HAZ CEO, who later became the city PCT CEO, to develop the public health agenda. Hayley was born and still lived in the city and was in her late 40s. Her background was a lawyer by profession. In 2001, after the general election, she entered the New Labour government as the Parliamentary Secretary of State at the Department of Health responsible for Public Health and held this position until 2003.	A Labour MP elected in the May 1997 general election, was responsible for strategic implementation of New Labour policies, she met regularly with CHAP.
3. Maria	Maria was a clinical nurse by background, in her late 40s, who lived and worked in the city. In 1999 to 2001, following the health and social care services being reconfigured, she was appointed to the role in the PCT of Director of Education and Research	Director of Education and Research PCT. As strategic lead in the PCT, she worked with clinicians and CAG.

8.4: Why the strategic respondents participated in the NDC programme

In Chapters 6 and 7, the analysis of the community and workforce respondents

suggests that at least one of their rationales for participating in the NDC programme was due to proximity; as they were either living or working within the ABI at the time of the development of the regeneration program. Opportunistically, the front-line workforce and the community had understood and embraced the opportunities which arose because of the Pathfinder bid. Analysis of the three strategic respondents suggests they deliberately moved into employed positions which happened to include the opportunity of working in the NDC. A part of the strategic role for each of the 3 respondents involved supporting and embedding a participatory approach to the reconfigured services in the changing health and social-care environment. The analysis also suggests that, following the introduction of central government's New Labour's regeneration NDC participatory policies, the three strategic respondents thought they could actively help redress some of the health inequalities and imbalance of service provision in Wassail and Boothtown.

8.5: Social enterprise- public health - workforce development in the NDC

Jenny was working in the HAZ as an executive director in a large social enterprise within the North West Region when she became directly involved in the strategic activity in Wassail and Boothtown NDC in 2001. Prior to 1999, she was involved in supporting and setting up community enterprises and had knowledge from their inceptions of a neighbourhood NDC regeneration programme and the Wassail and Boothtown Pathfinder:

'*So it was from 1999 [was when I first got involved in NDC], I could be wrong. I remember I had an indirect role involved when I was setting up the Millennium Awards. So I did engage and talk to a lot of people at the time'* (Jenny: 39 – 41).

Discussing her earlier experiences as a clinician, she said she had moved into working within communities when she first became involved in the development of the social housing sector. In the 1990s, Jenny had had a previous strategic position supporting the SRB regeneration programme in a neighbouring inner city. Working with communities subject to a council house clearance programme, she experienced working in partnership to find solutions to tackle the economic, social and physical problems in deprived areas:

'*I was in [community] development and worked around issues related to social housing and [in] a number of the early 'home zones' in partnership with the local community.*

[It was whilst] working with the local communities, and yes mapping provision when I took the lead. Then when we got the different government. New Labour were elected.' (Jenny: 60 – 62)

When she began her secondment into housing she identified the key feature of her occupation as *'to reach communities.'* (Jenny: 79) The Millennium Awards programme was being delivered centrally across the North West region from the HAZ when I initially began working with Jenny. I found that she had skills in financial management, developing community capacity and the ability to link operational and tactical actors.

It was about this same time that I met Hayley, who was the Labour Member of Parliament for the city and had entered the House of Commons in May 1997, just as she began working extensively with the HAZ CEO [pseudonym: Frida Higgins]. It was working together with Hayley and Frida (who later became the city's first PCT CEO), that I began to develop the health regeneration agenda. Because of this role, I gained first-hand experience of the new strategic public health participatory involvement models, and an opportunity to support local actors who began developing some of the first examples of participatory community governance. I met with Hayley approximately twice a month during the years 1999-2001 and experienced her, at that time, as committed to deepening community participation and increasing involvement of local actors. After the 2001 general election, Hayley became the Parliamentary Secretary of State at the Department of Health responsible for Public Health. It was in this public health position that, together with CHAP, she began having regular scheduled meetings with the community. The transcript discusses her approach:

'I've always believed the ordinary working class people are more than capable of making complex choices, making rational decisions, absorbing quite complex situations and knowing what's best for them and for their families. And if you start from that starting point of respecting people and not from the starting point of I'm professional now. What is it now! That ethos trips a lot of people up into 'doing to them', that actually exists a lot' (Hayley: 157–163). Hayley discusses in her interview transcript the importance, for her, of supporting and connecting the work of CHAP, and looking at innovative ways to meet needs. She was also profiling this work in the national media and encouraging her colleagues in government to visit the NDC. In 2003, her transcript mentions her role changing, moving from the Department of Health to becoming the Minister of State at the New Labour Home Office with

responsibilities for policing, crime reduction and counter-terrorism. Her concentrated involvement with the CHAP group was from 1999-2003. Hayley mentions how she had moved from working in NDC, but identified part of her new role post-2003 as still including working within social enterprise. Briefly highlighting the financial aspects of her work and that she was still looking to establish economic solutions using the development of social enterprises she said:

'[I'm still] *working very much with social enterprise now and I'm still doing [work around] social values now – trying to change the way companies work! Investing in local communities and making a difference. And I'm involved in social investment, trying to mobilise and release private capital for social good. So I'm still doing and I will continue on doing because I still care about it!'* (Hayley: 2-7). The transcript illustrates her post-2003 as working within the wider city with a focus on policing rather than on NDC.

The third respondent, Maria, discusses her background as a clinical nurse and the health and social care reconfiguration changes that she experienced first-hand, when she was appointed to one of the new director posts within the Primary Care Trust in 2001. This respondent's data mentions that she had previously worked within the community trust, from 1999 to 2001, as the Pathfinder bid was being developed. Prior to her appointment role as PCT Director of Education and Research, she had been in a clinical, senior role, managing community nurses, including health visitors, in the city community health trust. In the newly formed PCT she was working with the front-line workforce:

'*I was in an educational coordination role, at that time, which was very new. And we were a teaching trust. I had this new post and I thought 'now how can I use this?' and – on reflection [thought] we could start to get some CPD [with the workforce] going which was equitable, and appropriate - with somebody - perhaps that knew what they were doing!'* (Maria: 71 – 78).

I acknowledge that my data sample includes only 3 strategic respondents, but they cover perspectives of implementing policy; working with the front-line workers; and directly interfacing with the community actors to help develop community social enterprise. The strategic respondents also had a direct working relationship with some of the other 12 front-line workforce and local community respondents interviewed in the research.

8.6: Spaces for partnerships

I have highlighted already that the community respondents thought that having informal access to and support from key strategic players was very helpful. This is discussed in Chapter 7. These meetings between community and strategic players allowed a joint space to reflect and process NDC health issues that arose within a supportive environment. I believe these spaces helped the community gain confidence and trust. The community respondents said they experienced being listened to by key high profile strategic actors. In the early years of the delivery of the NDC programme, I observed all 3 strategic respondents sharing information and working across the different sectors with the senior strategic, tactical, vertical actors and also the operational, front-line, local people, as well as the horizontal local actors. The local actors discussed in Chapters 6 and 7 experienced both Frida (CEO) and Hayley as accessible and supportive to the NDC work. The community respondents' data documents these strategic respondents as keen to be involved with CHAP HFG community health work.

8.6.1: Communication across Strategic Managers and Local Community Actors

It was from 2001-2003 that Hayley and a group of people from CHAP met regularly, on average every 4/6 weeks. These spaces offered an opportunity for dialogue, to communicate in a protected space and to update both the strategic respondent and the local actors on the progress of the NDC. I believe it helped having a protected space that allowed the local community to identify issues and situations as they arose to be discussed and debate solutions. My experience across the 4 years of working closely with Hayley was that she was an astute, political actor who listened to the community. In the regular meetings with CHAP, she appeared to value the interactions and insights she gained from the time spent with them. These meetings with CHAP also allowed her to publicise her public health work with her constituents and wider colleagues. Hayley's profiling of the NDC work related to the CHAP and HFG meant that they had national and regional publicity. One aspect of this publicity was positive as it documented and helped profile the new health activities. However, it was also a cause of tensions and jealousies from both the incoming tactical managers and increased competition within the NDC. The transcript identifies that she translated complex situations strategically by listening and understanding what was needed in

the community and she recorded that it was important to listen and respect the local community actors. In between the meetings, CHAP would save operational issues for these discussions. Occasionally Hayley would call an earlier meeting if she had something specific that she wanted to share from a strategic perspective with the community.

The two-way communication helped cultivate a strong bond between the community members and this respondent from 1999-2003. Another strategic respondent, Jenny, discusses her evolving role in the New Deal for Communities' area, however analysis of the data identified that it was not until early 2002 that her CEO sanctioned her widening the organisation's activity to strategically support the development of models of local community involvement. Together with senior directors in the voluntary sector, she had wide experience of working on shaping models of community engagement which may have been instrumental in ensuring greater community participation earlier in the process. Her work portfolio consisted of:

'mainly [supporting the implementation of] overarching community programmes, focusing on all local people in Manchester, Salford and Trafford' (Jenny: 81–84).

It was not until late 2002/early 2003 that Jenny was commissioned by the NDC to support the CHAP board to develop learning and peer support models in both HFG and CHAP. Members, front-line workers and local people began exploring the existing models of community governance within the health sector and made trips to neighbouring cities and London, learning about models such as Bromley-by-Bow which was based on the Peckham Health Project model. These models of health and social-care delivery were inspirational to the HFG and CHAP group members. By 2001/2, the NDC HFG had submitted the bid with an overarching brief to commission Jenny, on behalf of her agency, to support the CHAP board's development in co-managing the proposed new health facilities in the NDC:

'That was when you and the CHAP members, well you'd previously approached Big Life to support with some of the developing picture around the board. Those negotiations had taken a bit of time and, initially, they were with somebody else, but at some point you and I had connected roles [to develop the capacity of CHAP].' (Jenny, 1/6: 116–121).

The data analysis of the strategic respondents' documents suggests that early in the

process 2000–2001, a number of models of good practice were being shared from the first three years of the NDC programme. However, it was not until 2002/3 that the respondent Jenny's organisation was commissioned on a 3-year contract to provide additional support to help CHAP develop as a social enterprise and widen and embed the health work in the local community.

8.7: Workforce development and financial management in the NDC

The respondents' data analysis suggests that they were aware of the strategic challenges that this workforce-change agenda posed from their different perspectives. Jenny's transcript outlines how, by 2002, the charity who employed her had shared working policies with the NDC Partnership Board and HFG/CHAP to support their positive-discrimination, employment policy focusing on community actors. This was ratified by the NDC and accepted by the city LA/PCT. These new policies increased local community members' involvement and enabled local residents to apply for any new health and social-care positions, allowing the NDC to offer enhanced opportunities for employment. Previously, local applicants who did not have the appropriate, certificated qualifications were excluded from applying. This newly agreed CHAP policy allowed more community residents to be included in the emerging job interviews, as they were able to highlight skills and experience as well as certificated qualifications. This change allowed more local people the opportunity to apply for some of the new health and social-care NDC posts, including the newly commissioned NDC children's health and play workers. This was critically significant to rebalancing equality of opportunity around supporting the employment of local people. Previously, many non-residents had come into the area from the surrounding districts and secured the NDC jobs.

Jenny's data comments on the strategic role she had in sharing these newly emerging health models with the LA/PCT and NDC. Initially, the NDC agreed that the financial probity for any growing business located within CHAP would be held as the responsibility of the company that Jenny was a director within. Then, incrementally, over an 18 month period, as CHAP moved into becoming a robust entity and a community interest company, the shift of overall management would be moved directly into Wassail and Boothtown CHAP:

'I had [the role of offering] some structural services to the board. First we looked at the

different comparisons of what the charity I work within might provide, and looked at how best that was being in the hands of local people - and who to draw on. It was decided that my company services could be drawn down [as needed] and then [initially] all the money would go through my company services and [my company would] take out [its commission fee]. We felt the local people, together, have more zest and that CHAP should manage the budget.' (Jenny, 14: 3-152)

In these new, emerging, complex situations, Jenny's data indicates that she clearly understood her role as to support '*the local people to keep control*' (p.181) and the company she was employed through was taking a commission from the NDC to help ensure this.

Whilst Maria's transcript did document the newly formed PCT workforce respondents' willingness and passion to ensure that involvement with service users was central to the public health work, is also highlights that she felt there was an emphasis on the need to financially manage the work, and there was a general confusion amongst the front-line workforce, both with the PCT health service reconfiguration and in the delivery of the NDC.

All 3 respondents identified that one problem was that people were working within separate zones, not connecting or overlapping, and they acknowledged the complexity of integrating units and changing the system. Haley suggested:

'*Unless you have work connected it doesn't function as a whole. We need to work across integrated connected units. Yes, because we were trying to change the mainstream. That's what we're trying to do. And if you're just a project, carried on doing it in isolation on your own. It should be about changing the way the world works. Yes. In order to do it though you need the support from the top and the bottom and the middle.'* (Hayley: 10–21)

The PCT Director transcript discusses the many changes of staff with different people coming in, different directors and managers swapping and changing jobs and roles and the problems with ineffectual communication and the challenges that this '*gap between the top, middle and the coalface bottom'* caused. Her data describes her frustration that, although there was some level of understanding about the need to work together, this was not happening. Maria's transcript also suggests that many of the front-line tactical workers were aware of communication problems:

'Many of us who were not quite coalface workers could see the issues from both sides. (Maria: 170–173).

Critically, this was partly because of poor communication, as Maria's data suggested, and partly because there was a dissonance between what strategic actors such as Frida Higgins, PCT CEO (2001/3) thought she was achieving in relation to effective communication with the front-line workforce, and the reality. Maria's analysis suggests the clinical workforce did not understand this CEO, relate to or trust her:

'*There was no link between her and the people who were delivering the work, and I think unfortunately she thought there was'* (Maria: 58-61).

Interestingly this was the same individual that the local community document in the data as having a close communication and connection with. This lack of communication with her front-line staff was compounded further, as Maria describes even more staff changes and her frustration with meeting for the first time the new PCT CEO in 2003/4 in the PCT headquarters' lift.

'*We have had to work through all the chief changes. One of them, in fact I, err, met the Chief Executive in the lift. He just said to me 'You look a bit fed up?' And I thought... Because I didn't actually know who he was… I'm not really sure who I was talking to... So I just said 'Oh well sometimes a job gets you down.' And then we discussed various things-just in the lift-I think there had just been this BBC programme something like a Panorama about the poverty specifically in the city, and I just mentioned that. And I said to him 'Do you ever go out and actually see what your workers do?' And his response was 'I don't need to do that.' I said 'No maybe you don't. But it would give you a little insight into what your staff are dealing with on a day-to-day basis!' In those very, very difficult years what they had to work with! It was that divorced attitude. Not my job! Is it somebody else's? They do that. That is somebody else's job. I suppose at that level - I can understand, but that they should be that divorced?'* (Maria: 141-159)

The data analysis identified that the Chief Executive of the PCT, whilst she was CEO of HAZ between 1999 to 2001, had developed a close rapport with the local people. However the strategic respondent data analysis stated that by 2003 the incoming CEO, in her opinion, was not listening to the front-line PCT workforce. As the PCT reconfiguration had been completed and the new CEO came into post, Maria sums up

her first experience of encountering the new PCT CEO in the lift as not being introduced and that he had a '*divorced attitude*.' This strategic respondent data suggests that he did not know the population demographics and that he did not think it was his role to understand them. The new incoming PCT CEO had previously been the PCT Finance Director.

8.8: CHAP and PCT communication

The analysis of Jenny's interview identifies how the NDC structures allowed her employing charity to provide support to CHAP to help build the CHAP board's capacity whilst also maintaining financial probity. However, her data states that, in her opinion, not everyone wanted the CHAP board members to become directly stronger as individuals. She describes how a '*brokerage team'*, funded separately through the NDC, seemingly to be speaking on behalf of the CHAP board with the PCT 6-8 months after her appointment, when she states:

'I realised everyone round the table didn't have the same ambitions. I mean the advisers' (Jenny: 202 -206).

In addition to the charity Jenny worked within, the CHAP board had two other external advisers, ID and BD, who had been appointed to work within the NDC area. These individuals linked directly inside of the PCT to a number of key specialist Primary Care Trust (SPCT) directors who had responsibility for developing the physical infrastructure.

'*The advisers is what I mean (ID and BD). I felt the local people had the same vision - more or less - although sometimes they weren't, and although there was a difference much later. But more or less people on the same route. But it was because the external advisers were overcautious. Over cautiousness in a belief about the other external advisers to the community group - and what they could do. They put this [information and their opinion] into the PCT [without CHAP been consulted]. They said they could do this [take the lead for CHAP] and go for something lesser, that could curtail people'* (Jenny: 206 -215)

It was documented within the community respondents' data analysis, and Jenny's data also refers to these external advisers in summer 2003 who, in her opinion, began to speak on behalf of the community. This was without CHAP's knowledge or the board having subsequent sight of the PCT minutes of these meetings. This lack of

confidence from the external advisers in CHAP compounded the problem and Jenny discusses how this increased the PCT's anxieties about the community's ability to undertake the agreed, community governance model. However, in Jenny's transcripts, she believed that people were always going to have anxieties about local people being in control, and it was always going to be difficult. Her data suggests that she should have supported closed, internal development within CHAP. When the CHAP board undertook its business, my observations noted that, whilst its members trusted each other, they also had lively discussions and debates prior to arriving at a consensus agreement. Aspects of their work could be construed as conflict:

'I realise that there was one thing I would have done differently to support local people to take the lead in the health care delivery rather than the PCT. I would have separately worked with any disagreement that the CHAP board had off the patch so that every time they came to the board they would been a stronger voice, otherwise the board were caught up in internal conflict.' (Jenny: 275–281)

However, as more strategic people came into the city in 2002 with the health and social-care reorganisation, including the newly appointed strategic directors internal to the PCT and the external NDC advisers, control of the NDC health agenda moved on. Jenny's transcript documents that the transparency and communication around the decision-making process moved out of the domain of the local people and then the PCT withdrew decision-making power from CHAP in 2003/4:

'And the PCT set up and just said basically, 'No'' (Jenny: 227–228).

Analysing the data from all 15 respondents confirms that the complex multi-layered governance and decision-making taking place in different domains, changes in membership of the NDC Partnership Board and the PCT, and the introduction of new Treasury pressures in 2003 led to the CHAP Board losing its active participation in the decision-making arena.

8.9: Front-line workforce - PCT

Based within the PCT's central offices, the strategic respondent Maria's data documents that her work entailed complicated negotiations with two different universities, to try and meet the professional development needs of the staff. She describes this anomaly and the transcript analysis identifies some of the complex issues that arose while working to develop strategic educational programmes with

front-line workers:

'The main focus on the educational development work was unfortunately clinical governance focus. Which you would expect it to be, with quality – and very much focused on the research. What could we do that would bring money! And 'What basis could we do that?' So that the basic education that staff needed - at that particular time, to enhance skills, and bring them up to date… Opportunities were frittered away really. We weren't linked to the right university! Because the university that we were linked to with our finances actually taught pre-registration nurses. It didn't have a community angle to it. Although as we were, Bolton PCT and The City PCT were linked into them for the finances. Which then meant they didn't provide the education we actually needed!' (Maria: 78 – 91).

The transition of area-based health and social-care services reorganised within community primary care, with new partners, resulted in new and complicated ways of working across pathways, which were only just developing and evolving by 2003. These new relationships and pathways resulted in very complex networks being linked to the new finance systems. Maria identifies that austerity and resolving any finance demands first was critical for her, before she could begin to meet the professional development needs of the staff. Maria's data analysis also suggests she has insight into the complex demands of the multiple, changing environment experienced by the operational staff. '*I think it was about like 'Let's balance the books. Let's get the finances sorted out.' However, there were many of us, many of us who were not quite coalface workers who could see the issues from both sides. People were really quite confused as to what we were <u>really trying</u> to do.'* (Maria: 167-172)

The front-line workforce respondents' data confirms Hayley's data that by 2013, new middle managers, new monitoring systems and new ways of working were all causing workforce confusion.

Interestingly however, the strategic respondent Haley's transcript analysis identifies that she perceived an on-going role in influencing the workforce development in delivering health and social care using community engagement models which gave a real, community-focus perspective. She outlined in her transcript what she thought were some of the difficulties the NDC experienced in achieving an integrated model of joint working with the community in the middle:

'*We had a number of models that happened [in the NDC] and I think that's a very big challenge for government both locally and nationally, so they actually reorganise themselves. We talk a lot about whole person care, we talk about services being arranged around the person, but I don't think we have any set of professional workers who have been reconfigured to be comfortable in [delivering] that, at all!'* (Hayley: 106-113).

New Labour's NDC regeneration policy suggested increasing community participation, and their alternative model is with the local actor in the centre and services being arranged 360% around the person. The transformation that we were working towards within the NDC was about developing participatory community governance models, however at a similar time, the centralist Treasury decisions and global financial downturn was causing further reconfigurations of health and social care services.

8.10: Structures for participatory new partnerships and opportunities

Together with the data from the previous twelve respondents, the analysis of the strategic respondents' data adds to a complex, emerging picture of people's first-hand perception of the new structures for participation and the new partnerships and opportunities the area-based initiative introduced. All three strategic transcripts document involvement within the NDC with local actors, however the on-going work of all three respondents moved out of the ABI after 3/4 years, into the wider city. The transcripts identified that the respondents understood aspects of community governance and may have even believed in the importance of developing social capacity and a joint public-health agenda. However, I think on-going joint work was unsustainable without a lasting legacy as it was not embedded in the NDC as a way of working, and the new incoming strategic actors did not continue to support the participatory approach.

The community, workforce and strategic respondents' data analysis suggests that they saw the introduction of the new health structures, as a result of the NDC programme, brought the possibility of changing the mainstream and the health and social-care systems, and the data documents that the introduction of these new, complex ways of working could support greater, integrated community participation. However, the strategic respondents' transcripts also highlight some of the barriers to achieving these changes. Communication problems and centralist pressures on tactical and strategic

actors to manage financially appeared to derail the NDC processes with the potential for on-going joint work not being embedded or supported much past 2002/3.

8.11: The achievements and the barriers

The strategic respondents' data acknowledges the impacts of introducing the policy changes into the area-based initiative as complex and challenging and requiring a major system change: *'change the system, so it positively encouraged new forms of behaviour'* (Hayley: 26). One of the proposed models she discusses is integrated health and social care services being arranged around '*the person.*' The data transcript suggests that the workforce had problems and that they did not develop an integrated model in the NDC as people needed to be comfortable with the changes. It suggests that it is important to involve people in coproduction, and that it was an evidence-based approach. '*Doing it with people rather than doing it to them*' (Hayley: 119–120) and also sharing a reduced budget was part of the transformation process '[what] *will make it happen faster is austerity'* (Hayley: 114*)* because people will work together*.* The analysis suggests that, whilst the NDC programme did not manage to achieve this, it demonstrated the importance of developing new models with local people in control. One respondent's transcript identified what she thought the NDC had achieved:

'*I think the new deal did quite well in tackling some of the health issues. It did some good stuff about empowering people, which is more difficult to measure and making people feel proud of themselves and their community. Also more of a sense of 'can do'* (Hayley: 203 – 206). Conversely her transcript identified that some of the reasons the NDC did not achieve change in the ABI health status was because it did not deliver for long enough: *'If I'm honest, maybe it needed to go on longer. Making it more pleasant for people to stay (in the area). Maybe it was because we were starting from so far behind?* '(Hayley: 203–206). I note in my analysis that all 3 strategic respondents had moved from working strategically within the NDC programme, and no longer met with the CHAP.

Maria's data discusses the impact of the massive organisational reconfiguration with its impact on the front-line, clinical workforce. Her transcript suggested there was a complex set of financial infrastructures and budget constraints that resulted not only in money being wasted, but also clinicians discouraged to work jointly with the community: *'There was a huge amount of money wasted. There were a lot of clinicians*

recounted. I can only talk about the health service part in that. It was awful, all clinicians we relied on and they had the willingness to take it [joint working] forward and make it work. However they were told we can't do that because of the purchaser provider split.' (Maria: 240 – 248)

Her data is confirmed in the workforce respondents' data: '*a surge of advanced practitioner roles';* (Maria: *249)* evolving. The data documented that, although the roles were interesting, they were not developed with the requisite educational programmes and the support needed to enable the clinicians to succeed in these new, joint-working initiatives: *'That was a new role and interesting role, but it wasn't developed, some levels of capability building would have been really nice so that the clinicians could have succeeded. The whole role wasn't understood, it was just created. I suppose it was touchy-feely role as nobody done it before, but they could have taken it further. I'm sure'* (Maria: 261–267).

Community initiatives such as the NDC and Sure Start were being developed without front-line consultation. Maria highlighted the negative impact of this health service reconfiguration, change agenda between 2000 and 2002 on the front-line workforce:

'Think that looking generally, the reconfiguration was a lot of heartache. Many people were fearful though for their jobs. Some of them didn't manage change very effectively, which was routine. There were some people who are thinking it is time to jump ship. And many people did! Particularly amongst the front-line managers who were, well they were confused as to what their new roles were going to be. And, umm, there was a lot of talk about redundancy and moving on. It was very unstable it wasn't a pleasant place to, err, actually be involved in those first few years. Different people coming in. Different people, different directors. Managers swapping and changing.' (Maria: 27-39) *'District nursing teams were being cut and reconfigured, and going into different areas. They were looking at the start of places like Sure Start having to be reintegrated, and various other things.'* (Maria: 44–50)

The research documented that during these management changes, key people were not effectively involved from a strategic perspective in the changes from the start. As a Health Development Manager and a researcher, I documented that large, open-space events occurred that involved large meetings of the clinical, front-line workforce with opportunities for information sharing and discussion about the implementation of the new, health and social-care changes. One strategic respondent clearly documents

that she saw these attempts at participation and engagement as ineffective:

'*To some extent the city wasn't really carried along with that. The Chief Executive spoke to us all. Unfortunately many people felt that it was a bit of 'lip service' exercise. It didn't sell the service particularly well. I think as well, although as a chief exec, she was always positive – and always very driven – but there was no link between her and the people who were delivering the work. And I think unfortunately she thought there was!'* (Maria: 52 – 61)

Maria's analysis indicates that the front-line workers, many of whom were actively involved in the delivery of the new health services, were quite cynical about these consultation exercises. She records that they identified that the Chief Executive herself, like them, was a nurse but it did not really matter who was at the top. Maria's transcript suggests that *'the coalface workers*' disengaged, there was poor communication with the management side of things, which quickly resulted in processes not being '*joined up*' and staff not feel valued.

Maria's data documents an evolving breakdown, and a gap opening up between the strategic and tactical and operational workforce in the redevelopment of the PCT because of a lack of active communication between the top, the middle and the '*coalface bottom'*. (Maria: 63)

Her data transcript records the impact of the strategic purchaser/ provider split and the need for her, as a senior director, to ensure financial probity and balance the financial books whilst managing the conflict. Sadly:

'the *nurturing of talent and the keeping of talent didn't appear to be of any interest to senior professionals in the trust at that time.'* (Maria: 111- 112)

8.12: Conclusions

I acknowledge that Chapter 8 is based on a purposeful sample of strategic respondents, chosen to represent national political, strategic PCT and Northwest voluntary sector perspectives. Although my sample is small, the 3 respondents' transcripts all identified from their different perspectives their complex, public-health role in implementing the New Labour NDC regeneration policy from 1998 to 2003.

By 2003/4, all three strategic respondents had changed roles and left their positions in the NDC area-based initiative. The process needed to successfully introduce and

embed the new NDC participatory legislation had not been thought through with regard to fully involving strategic, tactical and front-line workers. The data from the front-line workers and community respondents confirms the importance of support from the strategic respondents. The front-line workers and local community respondents also document how these strategic leaders changing roles had adversely impacted on their delivery in the NDC programme. All 3 strategic leaders interviewed had initially, at the start of the programme, influential positions involved in implementing NDC policy, financial governance and ensuring that joint participatory working was demonstrated to and validated with the local actors. At the time of the questionnaire data collection, they had all moved away from their previous job roles into new roles not involving the NDC. Central government had adjusted its focus by 2003/4, suggesting that the NDC programme became a victim of political short termism, with the changes having been introduced without sufficient planning time, a joined-up development phase or an agreed consensus on how to ensure the learning and changes were going to be embedded.

The data analysis highlights the rapid pace of the health system changes introduced by New Labour, involving substantial reconfiguration of local health and well-being provision, together with implementing the NDC programme changes for the workforce. Initially the respondents' interviews suggest that the inspirational leadership which emerged in 1999/2000 helped to develop a high-trust culture and improved communication between strategic and operational actors. As the central government and local transformation and change agenda continued at the same pace, the strategic respondents' data comments that people became disenfranchised and left, and the high levels of trust and communication evaporated. Maria's transcript notes the complex networks, with few really effective personnel, who were enhancing and communicating effectively working from the '*top to the bottom to the middle*', which meant that the trust relationship was damaged both with the front-line workers and the community. Communication and trust and involvement was documented by all of the fifteen respondents as critically important. One strategic respondent suggests that the impact on health services of this lack of joint working was significant:

'*I think in many areas we're now like 'picking up the pieces' for that lack of multi-agency, inter-agency work and trying to get communities to work together. This is part of the health visitor shift as well, trying to get communities to work together.'* (Maria:

236–230)

The city wide strategic managers' priorities were not the same as the ABI regeneration programme or of the community-engagement, development agenda. The HFG CHAP health changes agreed at the NDC Partnership Board prior to the strategic PCT personnel coming into position in 2001, a full two years after the Pathfinder NDC was awarded, suggested that the agendas did not stay aligned. This delay also suggested that the change of strategic personnel compounded a further gap between the operational, and the front-line workers who had been engaged at the beginning with the City Pathfinder.

Jenny's data highlights that when the strategic partners in the LA/PCT and NDC reversed the agreement to incrementally introduce the community governance, management model in the new NDC health-care facilities, this damaged both the reciprocity and any possible future involvement of communities. Specifically, the new strategic actors did not share their internal decision to stop this consultation process and this thinking damaged the honest communication previously being shared with the community.

Analysis of Hayley's data suggests that what was needed was a multi-agency, shared agenda, sharing the data together, and people being co-located, working together with the families in the middle:

'People are 'located' and it's all about relationships rather than professional boundaries' (Hayley: 90–91)

Hayley's interview records that she can see pathways now which have emerged as a result of the NDC work and that she thinks that the capacity-building did not go to waste because I '*think it's changed people'*. In her opinion, people are more demanding:

'*the New Deal did quite well in tackling some of the health issues. We did some good stuff with empowering people which is more difficult to measure, making people feel proud of themselves and their community more of a sense of 'can do.'* (Hayley: 202–205)

Unless all the actors are aligned, working together towards a common, understood, agreed goal then as the strategic, tactical and operational actors experience dissonance, it unbalances both them and the intended policy outcome:

'*I think you must need every bit of the system facing in the same way. It can be moving at different speeds but if you haven't got that alignment I think you're in constant protest mode.'* (Hayley: 19–21)

The research data analysis conclusions documented that the centralist, strategic, health and social-care transformation and rapid pace of change resulted in the incoming staff and directors being unaware of what the operational workforce were doing on a day-to-day basis. Key individuals, such as the incoming PCT chief executive in 2003, were seemingly unaware of the population health needs, or the prior commitment to adopting participatory policies in order to influence and reduce health inequalities. The role of the wider financial constraints was also mentioned in the strategic respondents' data with the time demands of financial management and resource allocation disrupting the implementation of the NDC programme. Communication problems and centralist pressure to manage financial constraints derailed the process over time. The research highlighted the need to not only devolve power, but also develop integrated structures across strategic front-line workers including the community if such initiatives are to succeed and embed in the future.

9: Conclusions

9.1: Introduction

This thesis systematically examined the respondents' experiences and opinions over the longitudinal timeframe to understand the impacts that the introduction of the New Deal for Communities ten-year regeneration policy had on participation. It critically explored the increased participatory, democratic spaces and political-policy discourse that emerged under the NDC. The research explored the active community participation strategies as they emerged, and systematically examined both the introduction and implementation of the new, *'joined-up'* health and social-care legislation under New Labour's Third Way health-modernisation agenda. It acknowledges that the new health spaces and opportunities that emerged for participatory involvement of local actors in the HFG and CHAP supported joint decisions in the design and delivery of the health NDC programme. Concurrently, along the longitudinal timeline between 1998-2010, the thesis examined how this participatory joint working of the operational and strategic actors changed. The research considered how local people and front-line workers' experiences bridged the gap between the rhetoric of the participatory policies and the operational reality of their implementation.

9.2: Contribution to Knowledge

The research thesis contributes to the existing body of knowledge regarding the impact of the introduction and delivery of the NDC policy. It evidences that:

The NDC did involve the community and the front-line workforce in designing local health and well-being services, and that the local actors valued their involvement in the new participatory spaces;

Between 1998/2003, the local community contributed substantively and made active decisions and suggested shifts in local ways of working in partnership in the NDC health and well-being provision;

The national reconfiguration of the health welfare services, together with the local tactical and strategic management and front-line staff changes from 2003 onwards reduced communication and joint decision-making and introduced conflict in the NDC;

Following the initial introduction of New Labour's cross-government, centralist financial treasury policy, changes across the longitudinal timeframe from 1999-2007 conflicted with the participatory involvement of local actors and joined-up decision making in the NDC;

Vertical and horizontal communication systems and an alignment of operational, tactical, and strategic decision-making that includes the community is imperative for joint participatory involvement with local actors.

Regardless of the personal commitment of the individual actors, the introduction of policy changes to increase participation was derailed by political short-termism and insufficient planning time to develop joint partnerships and to embed the new joined up systems.

9.3: Review of the data

9.3.1: The value of the new participatory spaces that emerged

The data analysis identified that implementing the NDC programme framework did help open new participatory spaces which the local workforce and community people shaped and adopted. A recurrent theme in the data is that, between 1998–2003, these newly-established NDC health '*spaces*' incubated and supported the development of close, working relationships between front-line workers and local people. Within the new spaces, the local actors identified their own agenda, processes and discourse. What their priority health needs were and how they would like to deliver new ways of configuring local health services emerged out of the discussions that took place within these HFG and CHAP spaces.

9.3.2: Improvements in local health and well-being

Another recurrent theme that emerged from the data analysis was that people were motivated and opted into working in the NDC in the health programme with the intention of improving the poor local access and expanding the provision of health and well-being services locally. Additionally, the workforce respondents' data confirmed that it was important that the new NDC resources enabled the health sector to bring health services back into the geographical area whilst working in partnership with local people in developing health-service delivery.

9.3.3: Relationships and leadership

As catalysts for developing participatory change, leadership style, the individuals involved and being '*available*' were important themes identified in the analysis. All the research respondents suggested that people began working successfully together in collectives because of the connected conversations, growth of trust and '*face to face*' meetings which supported their participatory engagement. The focus was on people not policies. The data identified that joint working and participation with local actors suffered when key individuals and the leadership changed.

The community representatives' data confirmed that they thought it was critically important who the strategic leaders were, and whether they were accessible. The strategic leader's data suggested that at the inception, when the NDC was introduced into the area, their role involved acting as the connections between the tactical and operational actors in support of the joint participatory change agenda. Additionally, the data analysis identified the complex role of leaders in implementing the New Labour NDC health programme. It was important that the correct individuals were involved in the leadership of the programme because they could give strategic permission, support the local actor's participation in the operational delivery, and generally could make things happen.

9.3.4: New models of delivery involving the community

The thesis confirms that increased community participation did result in the development of new health service models, designed and delivered jointly with the involvement of local people operationally. For a limited period from 1999-2003, the NDC health regeneration agenda supported local actor's involvement and additionally, resources were allocated to fund these new work streams. Early in the NDC delivery, the NDC housed and piloted some unique health projects, including the '*Can Do'* Real Time Community Change projects, the Expert Patient Peer Training Programme, an innovative clinical, community complimentary primary care model, a pharmacy-carers led pilot and reinforced the role of health workers.

9.3.5: Community as decision makers

The data analysis, over the timeline from 1999 to 2003, documented that the workforce respondents understood the importance and the concepts of effective participatory

involvement with the local community. The transcripts document that the workforce respondents considered joint working with all partners in decision-making as critical to being able to achieve the NDC objectives.

'*In many areas we were working together 'picking up the pieces' from the past from having not working together. It was important; we were trying to get the communities to work together, as well as with the health visitor for the previous lack of multiagency interagency working*' (Maria: 226–231).

The data analysis clearly documents the theme of the growth of the workforces understanding of the possibilities of the NDC health activity as they piloted a new model of alternative community governance involving local people in decision-making and delivery.

9.3.6: Shifts in local ways of working in the NDC

During 2001-2004, within the new, health-action learning sets, the local actors began to develop and introduce new models of working locally within community health service delivery with greater involvement of local people in new, joint models of clinical, community and complementary therapy services, and more decisions about resource allocations being taken locally.

The respondents' data indicates an understanding of the importance of these new, participatory, interactive, connected ways of working with local people. The respondents' analysis also documents a desire to embed and continue post-2004 to address local health needs using the new, participatory, co-productive model. The data analysis suggests that for all respondents it was important that the NDC health activities left a legacy after the ten-year programme ended.

9.3.7: Health and welfare reconfiguration: staff changes

A re-occurring theme which emerged from the community, front-line workforce and strategic respondents' data was the impact that the health and local authority changes had on both the wider city and the NDC populations. In 2003-4, all three strategic respondents had changed roles and left their previous positions. These strategic leadership changes impacted adversely on the involvement of local front-line workers and the community in the delivery of the NDC programme. The health service transformation agenda and the changes in leadership after the HAZ/PCT CEO left had a direct impact on the participation agenda and the tactical, senior manager's

retraction from front-line working with the community. The increasingly complex health systems with multi-layered governance, multiple targets and increased focus on monitoring of progress helped local actors feel further distanced from transparent decision-making.

9.3.8: Decision making processes within NDC

Staff changes in the Primary Care Trust resulted in the new senior, strategic, health managers joining the city and the NDC Partnership Board in 2002/3, two years after it had become operational. It was specifically mentioned in the data that the changes of health representation on the NDC Partnership Board, alongside the impact of the national health and social care reconfiguration, resulted in local actors feeling further distanced from the NDC board's decision making.

From 2002/3, this alteration in the membership on the NDC Partnership Board and the changes regarding joint decision making resulted in the HFG/CHAP members feeling that decisions were being taken autonomously without them.

'I got that opinion through speaking to people that I've known for years, that lived in the community and people that had worked for New Deal from the beginning. And had just done a lot of the footwork. It felt like they weren't being told what was happening with the money and they weren't being able to make decisions about it. Meetings (in PCT) seem to go on but nothing was happening with them, with the community any more' (Joan: 311-321).

The previous agreed upon community governance arrangements and the models the community had developed failed to develop further or embed. The new PCT health representative on the NDC Partnership Board made health decisions and neglected to communicate effectively with the local people in the established CHAP or HFG structures. The data suggested that these new strategic health actors had reverted to discussions internally inside the PCT structures when making health decisions. Previously these health discussions had involved the community.

9.3.9: Longitudinal policy -staff changes: 2003 onwards

The rapid pace of health and social-care transformation resulted in the new incoming staff and directors being unaware of what the operational workforce had been doing

prior to their arrival. A theme emerging from the data was that, in 2003, the new PCT chief executive was seemingly unaware of the population's health needs, or the previous commitment to adopting participatory policies to influence and reduce health inequalities. I acknowledge my research was a small representative sample of strategic respondents. Noticeable in the data is that by 2007, all three had moved on to working within new strategic domains and left the NDC, unlike the on-going commitment of the front-line workers and local people who were still involved.

9.3.10: Conflict locally with cross government policies

The analysis of the delivery of the NDC programme along the longitudinal timeline identifies that, in 2003, respondents became aware of the LIFT work. The introduction of the public-private, finance initiative with the new partnership, tactical managers (the new PCT PFI work with the private investor) further shifted the governance from the NDC Partnership Board into the LIFT and Treasury governance mechanisms. Up to that point, a strong involvement of the respondents in developing the new health sites had been documented in the data. The respondents identified that the budgetary decisions were moved out of the NDC participatory model about the same time that the Treasury Department's public-private, finance initiative policy was introduced. In 2002/3, a re-occurring theme was the conflict arising from how the local actors wanted the health facilities configured in the NDC area. Their ideas on the community involvement and ownership of the proposed new clinical, community and complementary centres in the NDC area were negated. The introduction and implementation of the PFI policy and the LIFT programme, with its public, private partners and PCT governance structure, conflicted with the previous NDC regeneration, participatory policy agenda. Politics and political short-termism got in the way of participatory working, regardless of personal commitment from actors.

One respondent summed up how he understood the introduction of the LIFT additional finances and the NDC HFG focus to improve primary care estates:

'*Government Office introduced LIFT, a PFI initiative to build better quality GP premises. However, our centres became GP surgeries with elements of community activity not supported by CHAP.*' (Keith: 287-289)

9.3.11: Operational, tactical and strategic elements in alignment

A strong theme was that, unless all the actors are aligned, working together towards a common, understood, agreed goal then the strategic, tactical and operational actors experience dissonance and this unbalances both them and the intended policy outcomes.

'*I think you must need every bit of the system facing in the same way. It can be moving at different speeds but if you haven't got that alignment I think you're in constant protest model*' (Hayley: 19 – 21).

Personal empowerment was demonstrated by being meaningfully involved in the processes, with actors along the way gaining knowledge, confidence and skills. Wider political empowerment is still needed to support change in wider structural levels. In the intervening decades since the NDC policy was introduced, an even greater emphasis has been focused on involving staff and service users in change within areas such as neighbourhood management, self-management, increasingly moving to delivering health and welfare services in partnership with all-centred approach and the introduction of personalised budgets across England (NHSE, 2017).

9.4: Thesis aims and objectives

9.4.1: Thesis overview

The key elements needed and recommendations for future participatory health policy and practice in order to support changing the mainstream services using health spaces with the participatory involvement of local actors have been identified in this research.

The focus of my thesis questioned:

How the implementation of the NDC policy introduced new spaces for actors to work jointly and participate in designing health and well-being services and community governance;

The impact that the NDC programme had on the delivery and integration of the new health and well-being services, and local actors' views on those impacts;

The importance of relationships, leadership, and vertical and horizontal communication within the NDC; and

The community participatory empowerment legacy following the introduction and delivery of the NDC regeneration policy.

9.4.2: Chronological overview of thesis

The most cogent aspect of the research was to gain an understanding from the lived experiences and views of the local community, front-line workers and strategic actors in this area-based initiative in a city in the north of England. Chapter 1 introduced my previous experiences of engaging and working with people, as well as the focus of my thesis questions:

How did the New Deal for Communities programme increase community participation and community capacity from the perspective of the local actors?

Did the newly emerging community governance models impact on the delivery of the local health services?

Chapter 2 studied the conditions for citizen participation pre- and post-1998 and how those conditions changed when New Labour came into office and introduced many national and local health and social care service changes. The centralist, political Third Way ideology intentionally positioned participatory community governance models within its implementation of the regeneration and health policy agenda. This harnessed the previous community-development approaches. Chapter 2 also explored the dynamics of trust, reciprocity and capacity-building in both individuals and within collectives, and introduced social capital theory.

In Chapter 3, I addressed the wholesale reconfiguration of health, well-being and social care services with the adoption of a neighbourhood, public health-focused approach, together with a plethora of local management and monitoring mechanisms, which heralded a complex, changing environment for front-line workers and local people. These changes included the introduction of the NDC programme to create participatory involvement of local people in decision-making in areas of deprivation, and a review and reconfiguration of the management and provision of existing health and social care provision from the acute sector into the community.

Chapter 4 explored New Labour's repositioning of the health agenda within the broader, public health framework to begin to tackle the growing health divide within

populations. Limited resources introduced a proactive approach to both developing community capacity and dealing with health inequalities, which the literature review suggested was addressed by a new public health framework being introduced. The new public health agenda included incorporating the involvement of lay people in health decisions and introducing a joint, systematic, evidence-based approach. The tactics involved devolving greater local integration and enabling a more reflexive form of learning which, combined with increased monitoring and complex multi-layered governance, challenged the implementation of the agenda and inclusive integration.

In addition, Chapter 4 explores the introduction of New Labour's Third Way regeneration and health legislative changes. With the introduction of the Third Way, the metric of participation and community development was shifted from consultation and evolved into the elements claimed in the emerging wider debate about social-capital theory, which impacted at a national policy level. Chapter 4 highlights the conflicting policies that New Labour's Office of the Deputy Prime Minister and Treasury introduced, and within the main body of the thesis, the research analyses the impact of these operationally.

The review of the literature and exploration of the political and social policy framework in Chapters 2, 3 and 4 helped me reference and triangulate the main empirical themes from the respondents' interview data, the action learning, and contemporaneous notes. This focused my thesis to question the social-capital discourse, the emerging political economic shifts within New Labour, and the impact of centralist, economic and regeneration policies on community participation. This social policy and political context review acknowledged the complex environment as the NDC policy was introduced and positioned the research.

Chapter 5 introduces the tactics and processes I used to develop the contours of my final research strategy. I discuss my research methodology and how the research design journey led me to choose an action learning reflective approach to interrogate the spaces for change that the NDC programme opened. Together with analysis of the contemporaneous notes, my action learning research methodology focused on determining the views of the local community, front-line workforce, and strategic actors on how the New Labour Government's Third Way policies (1998-2004) and the longitudinal delivery strategy of the NDC regeneration programme had impacted on

their participation in health care locally. Further details of the process are given in Appendix 1.

To fully explore and triangulate the data findings, I chose respondents involved in the NDC delivery in three groups from the different perspectives of community, workforce and strategic participation. These respondents are described in Chapters 6, 7 and 8. New Labour's regeneration policies repeatedly stressed the importance of community involvement supporting the provision of a range of public services through active citizenship, together with social entrepreneurs acting as catalysts within the local initiatives that provided leadership. The idea of self-help was endorsed and fostered within New Labour's community participation agenda, so these regeneration policies had the potential to create the opportunities and spaces for local actors to work jointly in partnership. These three chapters focus on the key themes emerging from the analysis of the respondent's data, concentrating on what supported the involvement of local actors and what emerged in the NDC health programme.

9.5: Recommendations for participatory health policy and practice

These research findings document that across the 1999-2003/4 timeline, the respondents within the NDC HFG did participate in the democratic decision-making processes around substantial capital investment, physical and social infrastructure. As the budgeting dynamic changed with the introduction of a central Treasury PPFI policy, it was decided by the strategic actors in the PCT not to continue with the community-governance model designed by the operational NDC HFG community and the framework was dissolved in 2003/4.

To support the achievement of joint community participation, the research identified a key recommendation is to ensure that the centralist policies, emanating out of different departments, do not conflict directly with each other when being implemented as this has operational implications at a neighbourhood level.

A key recommendation is to understand the importance of communication pathways whilst maintaining and developing trust and alignment across operational, tactical and strategic actors. The research demonstrated that the operational, tactical, and strategic actors did communicate, and established a high trust culture and spaces for participatory involvement in the NDC HFG CHAP up until 2003.

An important recommendation is to disseminate the learning outside of the initial clusters to leave a sustained legacy of health policy change; this requires the involvement in practice of the wider actors across the vertical and horizontal axes, as well as continued strategic support and permission. Alignment and effective communication of all the strategic, tactical and operational systems and actors is needed to support sustained change. The central government's introduction of separate financial and regeneration policies with competing agendas from the Office of the Deputy Prime Minister and the Treasury department directly impacted on the area-based initiative by reducing transparent community participation in the allocation of finances and increasing central, capital resourced decision making.

Across the first four years of the ten-year timeline, the NDC policy supported the introduction and design of the emerging health themes generated and identified by the local population and front-line workers. A high-trust culture and effective communication is recommended to enhance joint working with community participation and co-production between key actor's. An on-going systematic sharing of transparent decision making recommended within the participatory health policy is needed to stimulate joint working with practitioners to create the environment that supported transformation and integrated change within health and social care.

Another recommendation is that there is a requirement for inspirational leadership from across both the vertical and horizontal axes and the development of dynamic vertical and horizontal communication, as it was seminal to maximise integration and sustain on-going community and local workforce participation. The initial processes of agreed decision making and transparent, open power-sharing, conflict management and analysis of outcomes and possible consequences of actions are intrinsic to engendering the trust needed to support community participation, building community capacity and sustaining reciprocity.

The use of reflective practice and, where appropriate, Action Learning Sets (ALS) are recommended to support the process of engendering a participatory non-hierarchical environment, which conversely supports the development of a high trust culture. Adoption of reflective practice and wider use of action-learning principles would also help participation in centralist health policy implementation within neighbourhoods.

Also, greater understanding around cluster management and non-hierarchical leadership with equitable power-sharing is recommended when introducing future health policy targeting joint working practice.

The NDC health programme supported the emerging new participatory spaces and the increased community governance models, which resulted in an additional 19 areas of joint health work being delivered between 1999 and 2004. The thesis explored the complex dynamics underpinning the action-learning sets, however the results recommend that more research is needed to understand the key features required to maximise and sustain on-going support from all relevant actors.

The legislation introduced by the New Labour central government (1998-2004) was intended to be a central catalyst for the organisational reconfiguration of the health and social care provision locally and increased managerial monitoring controls. Greater understanding is needed around the impact of increasing tactical strategic monitoring returns and complex performance indicators as they impact on the demands on the operational front-line workforces' time, reducing the time for working with the local community. A greater understanding of local communities' health and well-being needs, their views and aspirations and a culturally sensitive approach as to how the statutory organisations can effectively engage with the local actors would help embed more inclusive participatory practices.

9.6: Conclusion

The implementation of the NDC policy was a significant change in Wassail and Boothtown from 1999 to 2003, with more resources and spaces for, joint working, active community participation in identifying the health service changes, and more interpersonal collaboration and community engagement between the front-line workers and local people.

The introduction and implementation of conflicting central government policies was clearly indicated as a theme which impacted operationally on the ABI in 2002/3. Additionally, the central financial constraints, with the time demands of monitoring, workforce management and resource allocation involved in the reconfigured health and social care systems disrupted the process of embedding the learning from the early lessons learnt from the implementation of the NDC programme.

A key recommendation for future longitudinal research would be to scrutinise short-term political policies and legislation which are introduced from different cross government departments, examining them for their impacts and possible conflicts that would arise directly within neighbourhoods is necessary as issues change over time.

The NDC regeneration programme delivery policy stated that: '*The aim of introducing NDC programmes was initially to ensure greater stakeholder involvement and increased contribution of greater community participation in service delivery'* (NDC Delivery Plan, 2001).

The research findings identified that successful implementation of the new policies to increase community engagement required strong leadership, a commitment on an individual basis to supporting participatory democracy, and effective communication across both vertical and horizontal axes. Local people participated in more than one of the setting-based, focused NDC steering groups as well as within the health focus group. These included the building community capacity focus group, crime and community safety focus group, children and young people's focus group, physical and environmental focus group, and the education, employment, and the skills focus group. The importance of these focus groups and networks to understand people's views is clear. However, this participation did not equate to a greater community voice being translated into the NDC project implementation post-2004. The supportive strategic actors across the years 1999-2003 had a positive, direct impact on operational front-line staff, on networks, and on the local communities' ability to actively participate in the decisions that affected their own lives. The introduction of the regeneration policy and workforce legislation shifted the balance of power and allowed these new partnerships to flourish. However, this open vertical and horizontal communication declined from late 2003 to 2007 as the strategic actors' priorities shifted.

The data analysis also concludes that these settings-based cluster groups only functioned successfully when they operated within a supported, high-trust culture, where tactical and operational actors communicated effectively, and centralist policies were in alignment. Supplementary research is required to investigate this further to understand how to build sustained capacity for local actors to get involved.

My research findings conclude that the economic downturn from 2004-2009 reinforced the central government's commitment to a community, participatory agenda. Significantly, it identified that this involvement with both front-line workers and local people was not from a perspective of increasing community participation in joint governance with transparency on health resource decision making, but from a need to make fiscal savings in the delivery of public health and social care services and to harness social capital within the development of social collectives: '*what will make it [involving services being reorganised around the person] happen faster is austerity*' (Hayley: 286). Further research is required to identify in times of financial austerity the optimum ways to deliver local self-management and peer-led health and well-being services, with local actors having greater participation in development policy as well as the design and delivery of services.

The literature review identified that, following the introduction of New Labour's regeneration policy, the metric of community engagement significantly shifted from increased community participation to social-capital theory involving fiscal dynamics. The facilitation of collective spaces for participation and designing a changed health and well-being provision, in partnership with local actors, was piloted within this NDC research. The problems identified caused by the non-alignment of the central government agenda with the local tactical, operational, and strategic elements needs further research.

This research has concentrated on understanding the inside voice and local actor's views of the impact of the New Labour's regeneration and health policies as they were introduced and embedded locally. As my research developed, it identified the key emergent themes and the respondents' experiences of participation and involvement in the emerging ABI operational processes; all this learning is transferable and valuable in today's health and social-care systems. The opinions of the individuals involved in implementing participatory joined-up health regeneration policy suggest clear areas for focus which are useful in delivering health and social care policy today.

The research acknowledges that New Labour's NDC regeneration policy did successfully engage local social capacity and initially increased local control over decision-making. However, the hoped-for integration of sustained, greater community involvement in health and social services within the community failed. My research

suggests that the provision of primary health services became less equitable and New Labour's policies were a continuation of a neo-liberal market response to harness social capital to facilitate local capacity, driven partly by a reduced financial allocation by the central government for health and social care services. Additional research is needed to examine this further and understand how to identify a sustainable, longer-term, participatory community engagement framework and to build community capacity.

The direct impacts on the implementation of NDC policy in a local population by multiple and conflicting centralist policies provided some lessons learned for future central and local government and community strategic actors, and for health and social care provision to communities.

The political discourse under New Labour's Third Way also increased local citizen governance by harnessing social capital between years 1-3 of the NDC programme. However, the experiences of the local respondents along the longitudinal time framework from year 3/4 of the NDC programme changed, as the central government's Treasury department introduced new policies which conflicted with the activities managed by the Office of the Deputy Prime Minister Department of Communities, and this disrupted the community involvement in decisions related to the implementation of the NDC regeneration health focus group programme. The introduction of these competing centralist polices directly impacted on the NDC programme and decreased democratic citizen participation by the local population.

My thesis review found that the New Labour Party, prior to taking office, had adopted the Third Way ideology and designed what was heralded as participatory involvement and joint working in public health changes into local government/NHS policy and legislation. It also reconfigured health and social care and regeneration services, ostensibly to tackle the growing inequalities in society between the rich and the poor. This new central government policy focused on involving individuals and collectives working together within neighbourhoods, to identify health needs and services. A key feature underpinning the policies involved harnessing the individuals within neighbourhoods to develop sustained change and build the social capacity of communities into a new community governance model, with local people in charge.

Empirical observations suggest that from 1998 to early 2003, the NDC generated greater participation of local people and front-line workers, which resulted in different health and social care models with significant levels of community-governance and overall people and financial management by the community. The research clearly identified that central government's policy focus shifted with the Treasury department's introduction in 2002/3 of the NHS public-private finance initiatives away from community-governance and local communities towards more financial control.

My research identified that the introduction of public policy to increase joined-up participatory approaches did impact on the front-line workers and local community actors working to deliver the health agenda in the ABI. In the first three years (1999-2003/4) of the NDC programme, HFG/CHAP introduced 19 new joint health and well-being projects. Whilst my research evidenced an initial increase in community participation by local actors, this was impacted by the introduction of conflicting centralist, strategic public policies. There was a significant gap in the coordination of cross government participatory policies, evidenced as the Treasury department implemented the PPFI initiatives which took precedent within the NDC regeneration area. The NDC HFG/CHAP opened spaces for individual actors and collectives to work jointly together. As the CHAP continues to function as a community interest company this offers an on-going opportunity for further research.

Further research and analysis could scrutinise the impact of individual public policies on local actors, considering the on-going changes within the centralist political environment. There is a complex, changing and evolving set of relationships that influence nation states and global markets. Whilst health outcomes and technology has improved, the number of people living with long term conditions has grown. The self-management agendas have merged into welfare policy agendas with disabled people and other social care service users being particularly affected and with additional responsibilities for the front-line staff. These new relationships warrant further research if in the future local communities and the wider actors are to work together as part of the solution. This future research needs to analyse the local actor's participation against the current political climate. As I became involved in this research, I fully believed in the participatory joint model that the NDC front-line workers and local people invested in. I still believe the lessons learnt that relate to the development of the new models, by working equally with all the actors, can result in sustained

community governance and this learning needs to be integrated within local neighbourhood delivery practises. The challenges are surmountable, and by identifying the change agents and champions, accounting for the new sets of relationships across nation state and between markets, understanding power and finding common ground to develop communication and trust, we can replicate them across neighbourhoods today. I identified successful processes for participation, however the on-going sustained political participation policies shifted centrally and impacted directly on the local actors. Future research must look at the impact of central policies on local initiatives.

The development of shared learning and how to embed practise and develop operational and strategic joint participatory health agendas is set against this stark backdrop. The health divide continues to grow. We do not have an alternative.

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APPENDIX 1

Interpreting and Analysing the Research Data

Large quantities of information were generated over the longitudinal timeframe work of the study. To identify the significant features and key elements embedded in the data, I developed a framework for reviewing the transcripts and records, systematically combing through data to clarify using interpretive questions including *what* happened and *how* it happened.

My first phase involved identifying the information that was specifically related to my questions, as I had large amounts of data that were irrelevant or incidentally relevant. This initial phase of my analysis involved first reading, re-reading, working through the data, thinking, reflecting and interpreting interconnected ideas and activities. This necessitated re-reading and sorting through narrative descriptive accounts and large amounts of data, familiarising myself with and revisiting data.

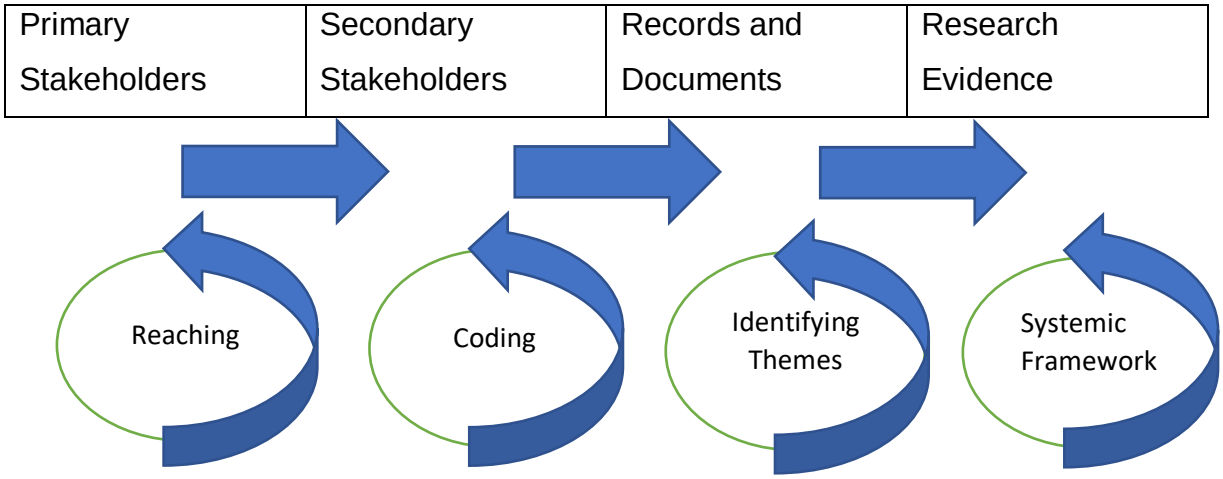
To initially begin identifying themes and understand which specific information may be relevant to the thesis research questions, I began coding and categorising once I was familiar with the data (Stringer, 2007 pp101-110). In the respondents' data, the linked experiences and perspectives had begun to appear with some aspects emerging that showed interrelated patterns and connected events and activities. Using different coloured pens, I highlighted units of meaning which could be either a word phrase or paragraph. I repeated this across the different respondents' transcripts, systematically recording, coding and categorising.

After this first stage I had identified and documented the key experiences and themes from the primary research respondents' data. Using the reflexive holistic approach of action research to enrich the analysis, and following my initial interpretation and identification of these emerging themes, I added data from relevant secondary stakeholders. This helped to clarify further and widen understanding across operational, tactical and strategic organisational domains in order to review the area-based initiative. I incorporated the same techniques used with the initial respondents and conducted semi-structured interviews with strategic and tactical respondents to support, deepen and make sense of the complex situations and data. These emergent frameworks of analysis from the local actor's data enabled and extended my understanding and incorporated diverse data into my emerging analysis. This

generated further information about their experiences and further refinement of key themes. Generating the evidence data involved processes which represented the situation truthfully and authentically. My systematic analysis identifies these stages and the process of transforming data into evidence (McNiff, 2009 p139)

Production of the research evidence

- Unitised the data;
- Categorising and coding;
- Developing systematically and organising;
- Analysing key experiences;
- Extending frameworks for interpretation; and
- Reflection and refinement (Stringer, 2007 p124)



Incorporating Diverse Data into an Emerging Analysis (adapted from Action Research, Stringer, 2007)

Appendix 2

Retyped questionnaire for NDC front-line workers and local people study 2000 – 2007.

Note scanned copies of the originals follow this:

After consent form discussed and signed / mentioned tape-recording interview.
(Interview prompt)
Thank you agreed to take part in the study. It is trying to capture what you think about the NDC. It started in 1999 to 2000. I would like to understand how you have helped influence those achievements, and what enabled you to get involved.
Okay the first question is just collecting data about you and your relationship with NDC.
(Closed questions taped)
1. These questions about who are you?

- Name
- Age
- Male/female
- Where do you live?
- How long have you lived your current address?

  More than 7 years move on to question viii

  Less than 7 years?
- If you've moved in the last 7 years, where were you before then?
- Why did you move?
- Do you work here?
- If answer is no move to x.

  (If yes) what is your occupation?
- Have you worked here?

- Yes. What was your occupation and when did you work here? Date

The NDC was set up to involve local people workers. (Respond if necessary) This section now is about what you think the NDC programme has achieved. Open-ended questions/prompts

2. Your hopes related NDC?
    - When did you first get involved?
    - Why? What prompted you to get involved in the first place? (Prompt)
    - Personal development
    - Political action
    - Love of community/rekindling community spirit
    - Professional satisfaction

3. Activities related to NDC?
    - Discuss examples of involvement?
    - Time, related
    - When?
    - How long?

iii. Involved in strategic/operational or both?

4. Outcomes?
    - Did you achieve you wishes about why you got involved?
    - What did you achieve?
    - What would you change?
    - Where the resources well spent?
    - Any additional training?

5. In your opinion did NDC achieve a substantial increase in the involvement from the communities?

6. Which three individuals have you worked the closest with in NDC?

7. As an insider to the whole process and practitioner researchers what did you personally learn? As a human being? As you? What do you think about that?
8. Any other comments?

Thank you for your cooperation and agreement to answer these questions. The transcript of the table will be available for your comments and amendments. Would you like to join a focus group discussion further to explore any other issues?

FJ Greenham

31.4.07

Letter to explain the purpose of the research interview and to ask participants consent.

Phil Greenham
118 Humphrey Rd
Old Trafford
Manchester
M16 9DF

7.5.07

Ref: Informed Consent and Explanations regarding the purpose of the research.

Dear

Thank you so much for agreeing to take part in the final stage of the data collection about Salford's New Deal for Communities and participations of local people and front line workers. I anticipate that the interview will be tape recorded and a transcript of the tape recording will be available for your comments and amendments.

Phil Greenham can be contacted by calling 07888749405

I have been informed that my participation and collaboration with the research is voluntary and that I can withdraw at any time.

....

Date Researchers signature

....

Date Participants signature

vii. Why did you move?

viii. Do you work here?

Yes No

ix. No, move on to question x. Yes, what is your occupation?

x. Have you worked here?

Yes No

xi. Yes, what was your occupation and when did you work here? Da

Occupation

Date

ire for NDC Front line Workers and Local People study 2000-2007

you?

i. Name

ii. Age

0-20 20-30 30-40 40-50 50-60 60-70 70-80

iii. Male / Female

Male Female

iv. Where do you live?

Lower Kersal Charlestown Salford Other

v. How long have you lived at your current address?

0-2 2-4 4-6 6-8 8-10 10-12 12-14 14-16 16-18 18- 20

More than 7 yrs move on to question viii

Less than 7 years, what year did you move there?

1999 2000 2001 2002 2003 2004 2005 2006 2007

vi. If you have moved in the last seven years, where were you before then?

Questionnaire for NDC Front line Workers and Local People study 2000-2007

Thank you for agreeing to take part in this research. It is trying to capture what you think about the NDC. Started in 1999-2000 I would like to understand *how you* have helped influence those achievements, and what *enabled you* to get involved.

OK the first questions are just collecting data about you and your relationship with NDC. Closed Questions Taped.

1. Who are you?

   i. Name
   ii. Age
   iii. Male / Female
   iv. Where do you live?
   v. How long have you lived at your current address?
      More than 7 yrs move on to question viii
      Less than 7 years?
   vi. If you have moved in the last seven years, where were you before then?
   vii. Why did you move?
   viii. Do you work here?
   ix. No, move on to question x. Yes, what is your occupation?
   x. Have you worked here?
   xi. Yes, what was your occupation and when did you work here? Date.

The NDC was set up to involve local people and workers. This section is about what you think the NDC program has achieved. Open Ended Prompts Taped.

place?

Personal Development
Political action
Love of community/rekindling community spirit
Professional satisfaction

3. Activities related to NDC?

    i. Examples of involvement?
    ii. Time related
        - When
        - For how long?
    iii. Involved in Strategic
        - Operational
        - Both

4. Outcomes?

    i. Did you achieve your wishes about why you got involved
    ii. What did you achieve?
    iii. What would you change?
    iv. Were the resources well spent? – additional training?

5. In your opinion did NDC achieve a substantial increase in involvement from communities?
6. Which 3 individuals have you worked the closest with in NDC?

7. As insiders to the whole process and practitioner researchers what did you personal learn? As a human being, as you? What do you think about that?
8. Any other comments?

Thank you for your co-operation and agreement to answer these questions. Would you like to join a focus group discussion about this issue with between 6-8 people?

F. J. Greenham
31.4.07

The purposes of the group discussion are:

- To understand more fully what front line workers and local people perceive the NDC regeneration program achieved?
- To understand which spaces FLWs and LP think NDC has introduced that has increased their involvement in decision making.
- To explore their views on what their role was within NDC both in the past and currently.
- To encourage them to express what the achievements have been.
- To encourage them to express what mechanisms have helped/hindered participation or developed trust?

	Topic	
1.	Introduction About the facilitator Background to research for NDC-problem of increased participation Purpose of the discussion – to help the facilitator understand the role of NDC and explore in greater depth their views of the problem Confidentiality of views expressed	5 mins
2.	About The Respondents Who they are (first names) What do they do? How do they relate to NDC?	15 mins
3.	What Are The Achievements?	15 mins
4.	What Are The Spaces That Have Opened Up?	15 mins
5.	What Have You Been Involved In?	15 mins

8.	What Has Hindered Your Involvement?	10mins
9.	What Would Have Made it More Likely that People Got Involved? Any Other Comments	15mins
10.	Summing Up Thank you for your involvement	5mins
	Total Duration:	2hrs

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